MENTAL HOSPITAL SERVICES MANUAL

Kentucky Medical Assistance Program
Mental Hospital Services Benefits
Policies and Procedures

Cabinet for Human Resources
Department for Medicaid Services
275 East Main Street
Frankfort, Kentucky 40621

TRANSMITTAL LOG FOR MANUAL UPDATES

The purpose of this log is to provide a record of changes, additions, and deletions in the KMAP Provider's Manual. As sequentially numbered transmittals are received and posted in the Provider's Manual, entry of the change number in the log is expected to provide the provider with a mechanism for eliminating errors and omissions.

TRANSMITTAL NUMBER	DATE	BY (Initials)	TRANSMITTAL NUMBER	DATE	BY (Initials)

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

MENTAL HOSPITAL SERVICES APPENDIX

SECTION I - INTRODUCTION

I. INTRODUCTION

A. Introduction

This new edition of the Kentucky Medical Assistance Program Mental Hospital Services Manual has been formulated with the intention of providing you, the provider with a useful tool for interpreting the procedures and policies of the Kentucky Medical Assistance Program. It has been designed to facilitate the processing of your claims for services provided to qualified recipients of Medicaid.

This manual is intended to provide basic information concerning coverage, billing, and policy. It will assist you in understanding what procedures are reimbursable, and will also enable you to have your claims processed with a minimum of time involved in processing rejections and making inquiries. It has been arranged in a loose-leaf format, with a decimal page numbering system which will allow policy and procedural changes to be transmitted to you in a form which may be immediately incorporated into the manual (i.e., page 7.6 might be replaced by new pages 7.6 and 7.7).

Precise adherence to policy is imperative. In order that your claims may be processed quickly and efficiently, it is extremely important that you follow the policies as described in this manual. Any questions concerning general agency policy should be directed to the Office of the Commissioner, Department for Medicaid Services, Cabinet for Human Resources, CHR Building, Frankfort, Kentucky 40621, or Phone (502) 564-4321. Questions concerning the application or interpretation of agency policy with regard to individual services should be directed to the Division of Policy and Provider Services, Department for Medicaid Services, Cabinet for Human Resources, CHR Building, Frankfort, Kentucky 40621, or Phone (502) 564-7759. Questions concerning billing procedures or the specific status of claims should be directed to EDS, P.O. Box 2009, Frankfort, KY 40602, or Phone (800) 372-2921 or (502) 227-2525.

B. Fiscal Agent

Effective December 1, 1983, Electronic Data Systems (EDS) began providing fiscal agent services for the operation of the Kentucky Medicaid Management Information System (MMIS). EDS receives and processes all claims for medical services provided to Kentucky Medicaid recipients.

SECTION II - KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP)

II. KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP)

A. General

The Kentucky Medical Assistance Program, frequently referred to as the Medicaid Program, is administered by the Cabinet for Human Resources, Department for Medicaid Services. The Medicaid Program, identified as Title XIX of the Social Security Act, was enacted in 1965, and operates according to a State Plan approved by the U. S. Department of Health and Human Services.

Title XIX is a joint Federal and State assistance program which provides payment for certain medical services provided to Kentucky recipients who lack sufficient income or other resources to meet the cost of such care. The basic objective of the Kentucky Medical Assistance Program is to aid the-medically indigent of Kentucky in obtaining quality medical care.

As a provider of medical services, you must be aware that the Department for Medicaid Services is bound by both Federal and State statutes and regulations governing the administration of the State Plan. KMAP cannot reimburse you for any services not covered by the plan. The state cannot be reimbursed by the federal government for monies improperly paid to providers of non-covered, unallowable medical services.

The Kentucky Medical Assistance Program, Title XIX, Medicaid, is not to be confused with Medicare. Medicare is a Federal program, identified as Title XVIII, basically serving persons 65 years of age and older, and some disabled persons under that age.

The Kentucky Medicaid Program serves eligible recipients of all ages. The coverage, either by Medicare or Medicaid, will be specified in the body of this manual in Section IV.

SECTION II - KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP)

B. Administrative Structure

The Department for Medicaid Services, Cabinet for Human Resources, bears the responsibility for developing, maintaining, and administering the policies and procedures, scopes of benefits, and basis for reimbursement for the medical care aspects of the Program. KMAP makes the actual payments to the providers of medical services, who have submitted claims for services within the scope of covered benefits which have been provided to eligible recipients.

Determination of the eligibility status of individuals and families for Medical Assistance benefits is a responsibility of the local Department for Social Insurance Offices, located in each county of the state.

C. Advisory Council

The Kentucky Medical Assistance Program is guided in policy-making decisions by the Advisory Council for Medical Assistance. In accordance with the conditions set forth in KRS 205.540, the Council is composed of seventeen members, including the Secretary of the Cabinet for Human Resources, who serves as an ex officio member. The remaining sixteen members are appointed by the Governor to four-year terms. Nine members represent the various professional groups providing services to Program recipients, and are appointed from a list of three nominees submitted by the applicable professional associations. The other seven members are lay citizens.

In accordance with the statutes, the Advisory Council meets at least every three months and as often as deemed necessary to accomplish their objectives.

In addition to the Advisory Council, the statutes make provision for a five-member technical advisory committee for certain provider groups and recipients. Membership on the technical advisory committees is decided by the professional organization that the technical advisory committee represents. The technical advisory committees provide for a broad professional representation to the Advisory Council.

As necessary, the Advisory Council appoints subcommittees or ad hoc committees responsible for studying specific issues and reporting their findings and recommendations to the Council.

D. Policy

The basic objective of the Kentucky Medical Assistance Program hereinafter referred to as 'YAP, is to assure the availability and accessibility of quality medical care to eligible Program recipients.

The 1967 amendments to the Social Security Law stipulates that Title XIX Programs have secondary liability for medical costs of Program recipients. That is, if the patient has an insurance policy, veteran's coverage, or other third party coverage of medical expenses, that party is primarily liable for the patient's medical expenses. The Medical Assistance Program has secondary liability. Accordingly, the provider of service should seek reimbursement from such third party groups for medical services provided. If you, as the provider, should receive payment from the KMAP before knowing of the third party's liability, a refund of that payment amount should be made to the KMAP, as the amount payable by KMAP shall be reduced by the amount of the third party obligation.

In addition to statutory and regulatory provisions, several specific policies have been established through the assistance of professional advisory committees. Principally, some of these policies are as follows:

All participating providers must agree to provide services in compliance with federal and state statutes regardless of sex, race, creed, religion, national origin, handicap, or age.

SECTION II - KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP)

Each medical professional is given the choice of whether or not to participate in the KMAP. From those professionals who have chosen to participate, the recipient may choose the one from whom he wishes to receive his/her medical care.

When KMAP makes payment for a covered service and the provider accepts the payment made by KMAP in accordance with the Department's fee structure, the amounts paid shall be considered payment in full; and no bill for the same service shall be tendered to the recipient, or payment for the same service accepted from the recipient.

Providers of medical service attest by their signatures (not facsimiles) that the presented claims are valid and in good faith. Fraudulent claims are punishable by fine and/or imprisonment.

All claims and substantiating records are auditable by both the Government of the United States and the Commonwealth of Kentucky.

Medical records and any other information regarding payments claimed must be maintained in an organized central file and furnished to the Cabinet upon request and made available for inspection and/or copying by Cabinet personnel. Such records must be maintained for a minimum of five (5) years and for any additional time as may be necessary in the event of an audit exception or other dispute.

All claims and payments are subject to rules and regulations issued from time to time by appropriate levels of federal and state legislative, judiciary and administrative branches.

All services to recipients of this Program shall be on a level of care at least equal to that extended private patients, and normally expected of a person serving the public in a professional capacity.

All recipients of this Program are entitled to the same level of confidentiality accorded patients not eligible for Medicaid benefits.

Professional services shall be periodically reviewed by peer groups within a given medical specialty.

All services are reviewed for recipient and provider abuse. Willful abuse by the provider may result in his/her suspension from Program participation. Abuse by the recipient may result in surveillance of the payable services he/she receives.

Claims will not be paid for services outside the scope of allowable benefits within a particular specialty. Likewise, claims will not be paid for services that required, but did not have, prior authorization by the Kentucky Medical Assistance Program.

Claims will not be paid for medically unnecessary items, services, or supplies.

When a recipient makes payment for a covered service, and such payment is accepted by the provider as either partial payment or payment in full for that service, no responsibility for reimbursement shall attach to the Cabinet and no bill for the same service shall be paid by the Cabinet.

E. Public Law 92-603 (As Amended)

Section 1909. (a) Whoever--

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit, or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under this title is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibiiity of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b)(l) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind--,

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person--

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to--

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(d) Whoever knowingly and wilfully--

(1) charges, for any service provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates estabiished by the State, or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)--

(A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or

(B) as a requirement for the patient's continued stay in such a facility,

when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan, shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

F. Timely Submission of Claims

In order to receive Federal Financial Participation, claims for covered services provided to eligible Title XIX recipients must be received by KMAP within twelve (12) months from the date of service. Claims received after that date will not be payable. This policy became effective August 23, 1979.

Claims received more than twelve (12) months after the date of service cannot be considered for payment unless documentation is attached showing timely receipt by KMAP and subsequent billing efforts. No more than twelve (12) months can elapse between each receipt by KMAP of the aged claim. Claim copies are not considered acceptable documentation of timely billing. An example of required documentation would be copies of Remittance Statements.

Claims for Title XVIII deductible and/or coinsurance amounts can be processed after the twelve-month time frame if they are received by KMAP within six (6) months of the Medicare paid date.

SECTION II - KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP)

G. Kentucky Patient Access and Care System (KenPAC)

KenPAC is a statewide patient care system which, as an adjunct to the Kentucky Medical Assistance Program (KMAP), provides certain categories of medical assistance recipients with a primary physician or family doctor. Only those recipients who receive Medicaid under the Aid to Families with Dependent Children (AFDC), or AFDC-related categories are covered by KenPAC. Specifically excluded are: the aged, blind, and disabled categories of recipients; skilled nursing facility (SNF), intermediate care facility (ICF), and personal care (PC) residents; mental hospital recipients; foster care cases; refugee cases; all spend-down cases; and all Lock-In cases. To aid in distinguishing from regular KMAP recipients, the KenPAC recipients will have a green KMAP card with the name, address, and telephone number of their primary care provider.

SECTION III - CONDITIONS OF PARTICIPATION

III. CONDITIONS OF PARTICIPATION

A. Requirements for Participation

A mental hospital is a facility which is primarily engaged in providing by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons. To be eligible for participation in the Program, a mental hospital must meet the Medicare conditions of participation for hospitals or be deemed to meet those conditions based on accreditation by the appropriate state agency, have in effect a utilization review plan and comply with additional staffing and medical record requirements necessary to carry out an active program of treatment and intensive care.

1. Appropriate Certification

a. Mental hospitals must be appropriately licensed by the Commonwealth of Kentucky.

b. Mental hospitals providing services to persons aged 65 and over must be certified for participation under Title XVIII of the Social Security Act (Medicare).

c. Mental hospitals must be accredited as a psychiatric hospital by the appropriate state agency.

2. Out-of-State Mental Hospitals

The Kentucky Medical Assistance Program does not routinely make payment to out-of-state mental hospitals.

3. Out-of-Country Mental Hospitals

Mental hospitals located outside the United States and Territories cannot participate in the KMAP.

SECTION III - CONDITIONS OF PARTICIPATION

B. Application for Participation

A mental hospital that meets the reauirements outlined in A. Requirements for Participation can submit an application for oarticioation to the KMAP. An aoolicant can not bill KMAP for services provided to eligible recipients prior to the assignment by KMAP of a provider number. The KMAP will not assign a provider number until all forms required for the application for participation are completed by the applicant, returned to the Department for Medicaid Services, and KMAP staff determine that the applicant is eligible to participate. Once an applicant is notified in writing of an assigned KMAP provider number, KMAP can be billed for covered services provided to eligible recipients. The application shall include the following:

1. Provider Agreement, MAP-343 (Rev. 5/86) (Appendix III-A)

2. Provider Information Sheet, MAP-344 (Rev. 8/85) (Appendix IV-A)

3. Certification of Conditions Met, MAP-346 (Rev. 8/82), if applicable (Appendix VIII)

   This certification shall be completed by all providers who have completed a Statement of Authorization (MAP-347) for whom the provider will submit professional component billings to the KMAP. The certification must be signed by the facility administrator and returned to KMAP prior to submission of any claims for professional component services. A new certification is required to be submitted for any changes which occur in the status of these physicians.

4. Statement of Authorization, MAP-347 (Appendix VI)

   This statement shall be signed and completed by all hospital-based physicians who will be providing services to KMAP recipients, and shall be retained in the hospital files.

5. Copy of accreditation report by the appropriate state agency.

6. Copy of Title XVIII certification when serving clients age 65 and over.

7. If a provider wishes to submit electronic media claims, the provider must complete and submit a Provider Agreement Addendum (MAP-380, Rev. 11/86). If a third party computer billing agency is used to prepare the media for the provider, the electronic media billing agency must also complete and submit an Agreement (MAP-246, Rev. 10/86). These completed forms should be mailed directly to the Department for Medicaid Services, Facility Services Branch, 275 East Main Street, Frankfort, Kentucky 40621.

C. Medical Records

Information must be maintained in each recipient's medical record which documents the need for admission and/or continued stay and appropriate utilization of services. Records must show that the services were furnished to the recipient during periods when the recipient was receiving intensive treatment services, admission and related services necessary for a diagnostic study, or equivalent services. For specific details, please refer to Section IV - Services Covered; E. Requirements for Inpatient Psychiatric Services.

The record and any other information regarding payments claimed must be maintained in an organized central file and furnished to the Cabinet upon request and made available for inspection and/or copying by Cabinet personnel.

Failure of the facility to provide to KMAP staff requested documentation will result in denial of payment for those billed services.

D. Termination of Participation

907 KAR 1:220 regulates the terms and conditions of provider participation and procedures for provider appeals. The Cabinet for Human Resources determines the terms and conditions for participation of vendors in the Kentucky Medical Assistance Program and may suspend, terminate, deny or not renew a vendor's provider agreement for "good cause." "Good cause" is defined as:

1. Misrepresenting or concealing facts in order to receive or to enable others to receive benefits;

2. Furnishing or ordering services under Medicaid that are substantially in excess of the recipient's needs or that fail to meet professionally recognized health care standards;

3. Misrepresenting factors concerning a facility's qualifications as a provider;-

4. Failure to comply with the terms and conditions for vendor participation in the program and to effectively render service to recipients; or

5. Submitting false or questionable charges to the agency.

The Kentucky Medical Assistance Program shall notify a provider in writing at least thirty (30) days prior to the effective date of any decision to terminate, suspend, deny or not renew a provider agreement. The notice will state:

1. The reasons for the decision;

2. The effective date;

3. The extent of its applicability to participation in the Medical Assistance Program;

4. The earliest date on which the Cabinet will accept a request for reinstatement;

5. The requirements and procedures for reinstatement; and

6. The appeal rights available to the excluded party.

The provider receiving such notice may request an evidentiary hearing. The request must be in writing and made within five (5) days of receipt of the notice.

The hearing shall be held within thirty (30) days of receipt of the written request, and a decision shall be rendered within thirty (30) days from the date all evidence and testimony is submitted. Technical rules of evidence shall not apply. The hearing shall be held before an impartial decision-maker appointed by the Secretary for Human Resources. When an evidentiary hearing is held, the provider is entitled to the following:

1. Timely written notice as to the basis of the adverse decision and disclosure of the evidence upon which the decision was based;

2. An opportunity to appear in person and introduce evidence to refute the basis of the adverse decision;

3. Counsel representing the provider;

4. An opportunity to be heard in person, to call witnesses, and to introduce documentary and other demonstrative evidence; and

5. An opportunity to cross-examine witnesses.

The written decision of the impartial hearing officer shall state the reasons for the decision and the evidence upon which the determination is based. The decision of the hearing officer is the final decision of the Cabinet for Human Resources.

These procedures apply to any individual provider who has received notice from the Cabinet of termination, suspension, denial or non-renewal of the provider agreement or of suspension from the Kentucky Medical Assistance Program, except in the case of an adverse action taken under Title XVIII (Medicare), binding upon the Medical Assistance Program. Adverse action taken against an individual provider under Medicare must be appealed through Medicare procedures.

A mental hospital wishing to terminate its agreement must submit a written request to the office of the Commissioner, Department for Medicaid Services at least thirty (30) days prior to the effective date of any decision to terminate or not renew its agreement. Services provided to KMAP recipients will be reimbursable by KMAP only for a period of thirty (30) days after the date of termination notification.

IV. SERVICES COVERED

A. Hospital Inpatient Services

1. Payable admissions are those for recipients age 65 and over or under age 21, who require psychiatric services on an inpatient basis.

2. A recipient who is in vendor payment status and is hospitalized and receiving covered psychiatric services at the time of the 21st birthday may be covered during a continuous hospitalization up to the age of 22, if the services continue to be medically necessary.

3. There is no maximum placed on duration of stay, provided the utilization review mechanism functioning in accordance with Title XVIII and/or Title XIX requirements deems the stay to be medically necessary and states that continued stay can be reasonably expected to improve the recipient's condition.

4. Before the KMAP can make full per diem payments for its recipients, the recipient must utilize all applicable benefits available under Title XVIII (Medicare). After exhaustion of benefit days available under Title XVIII, the utilization review mechanism of each hospital must then review the records of the KMAP recipient residing in the facility in accordance with current Title XIX requirements to determine if an extended stay is medically necessary and can be reasonably expected to improve the recipient's condition.

5. Inpatient psychiatric hospital services must involve active treatment which is reasonably expected to improve the patient's condition or prevent 'further regression, so that eventually such services will no longer be necessary.

SECTION IV - SERVICES COVERED

B. Limitations of Inpatient Services

1. Admissions for diagnostic purposes are covered only if the diagnostic procedures cannot be performed on an outpatient basis.

2. Patients may be permitted home visits; however, this must be clearly documented on billing statements as payment cannot be made for these days.

3. Private accommodations will be reimbursed by KMAP only if medically necessary and so ordered by the attending physician. The physician's orders for and description of reasons for private accommodations must be maintained in the recipient's medical records. If a private room is the only room available, payment will be made until another room becomes available. If all rooms on a particular floor or unit are private rooms, payment will be made. Documentation of such cases shall be made available to the Program upon request.

C. Exclusions From Coverage

1. Elective admissions.

2. Services to recipients between the ages of 22 and 64.

3. Substance abuse treatment services

4. Outpatient Services

D. Medicaid Eligibility Requirements

1. Residency Requirements

Under a contractual arrangement with the Department for Medicaid Services, the Department for Social Insurance determines the eliaibility of an applicant, or the continuing eligibility of a recipient for Medicaid benefits. Eligibility of SSI recipients for Medicaid benefits is determined by the Social Security Administration. Such determinations are binding upon the KMAP.

When admitting a patient from another state, the facility should immediately contact its county Department for Social Insurance office to assure that the eligibility of out-of-state persons is correctly determined.

Individuals who are patients in SNF, ICF, ICF-MR facilities, or Mental Hospitals must meet the following residency requirements:

-For any individual placed in an institution by any state, the residence is the state making the placement.

-For institutionalized individuals under age 21 and persons over age 21 who become mentally incapable before reaching age 21, their residence is their parent's or legal guardian's state of residence.

-If the parents live in separate states and there is no appointed legal guardian, the state of residence is the same as the parent applying for Medical Assistance on the institutionalized individual's behalf.

-If a parent cannot be located or refuses to apply, a facility may apply in behalf of an individual. In such instances, the state of residence is considered the state in which the facility is located even though the applicant's residence would normally be the parents' state of residence.

-For institutionalized persons who become mentally incapable at or after aae 21, the residence is the state where the person is physically present, except where another state makes placement.

-For any mentally capable institutionalized individual over age 21, the state of residence is the state where he/she is living with the intention to remain there permanently or for an indefinite period.

-If residency cannot be determined, as specified above, the state of residency is the state where the individual is physically located.

An individual whose MA eligibility is contingent upon inclusion as a member of an AFDC related group remains a resident of the state having jurisdiction of the family case. For example: an individual included in an AFDC related case does not abandon residency though forced by illness to seek care in a long term care facility in another state. Similarly, an individual from another state included in an AFDC related case in that state does not establish Kentucky residency so long as he/she remains an eligible member of that family group.

A child who is considered to be in the custody of the state remains a resident of that state having custody, regardless of the state where placed.

Any Supplemental Security Income (SSI) recipient who is residing in Kentucky, will continue to receive Medical Assistance from Kentucky. Residency is not determined.

2. General Criteria for Determining Appropriateness for Mental Hospital Benefits

Federal guidelines specify that a Medicaid recipient for whom Title XIX (KMAP) payment is made must require continuous and active inpatient psychiatric treatment and care in a facility specializing in psychiatric treatment and care.

The following may be used as general guidelines in determining whether a recipient meets Medical Assistance criteria for mental hospital benefits:

a. Appropriate for Inpatient Care:

(1) Patients with functional psychoses without significant concurrent illness for whom general hospital care or outpatient care is not feasible.

(2) Patients who require brief periods of protection from the consequences of their behavior during episodes of acute disturbance or depression (suicide, homicide, refusal to eat, etc.).

(3) Patients with acute or chronic psychiatric illness who require 24 hour care for diagnostic evaluation and psychiatric treatment.

(4) Patients with chronic mental illness who require protection and management, as well as treatment during periods of disruptive behavior requiring regular and freauent attendance of a physician.

(5) Patients with severe organic brain disease whose usual behavior is unresponsive to medication, and is too disturbing to be managed at home or in another facility, such as physically aggressive patient or person dangerous to himself.

(6) Patients who during episodes of agitation or restlessness produced by a stress situation may require brief mental hospital treatment.

b. Inappropriate for Inpatient Care:

The following care needs do not meet the criteria for mental hospital care:

(1) Persons with major medical problems and minor symptoms, or for whom psychiatric consultation might be utilized rather than mental hospital admission.

(2) Persons with inconsequential lapses of memory and mild disorientation as a result of chronic brain syndrome, who are more effectively treated or managed in their own homes, long term care facility, etc., and for whom a mental hospital has little to offer and may even aggravate their confusion.

(3) Patients who need only adequate living accommodations, economic aid, or social support services.

The above are oeneral guidelines and consideration should be given to each individual patient's needs. Federal regulations instruct that KMAP recipients may remain in a mental hospital only so long as there is a certified psychiatric need or such hospitalization can be expected to benefit them by effecting clinical recovery or significant symptomatic improvement.

Periodic medical and social evaluations should determine at what point a patient's pro@-ess has reached the stage where his/her needs can be met appropriately outside the institution.

Federal regulations emphasize "active treatment" as one of the necessary elements of inpatient services. Active treatment is defined as the implementation of a professionally developed individual plan of care which sets forth treatment objectives and therapies enabling the individual's functioning to improve to the point that institutional care is no longer necessary.

E. KMAP (Title XIX) Requirements for Inpatient Psychiatric Services

1. A mental hospital may request vendor payment from the KMAP for inpatient services for eligible KMAP recipients age 65 and over and under age 21, provided that:

   a. Medicare benefits are exhausted; or

   b. Recipient is not eligible for Medicare benefits; and

   c. Recipient meets Medical Assistance guidelines for mental hospital care.

2. PEERVIEW of Indiana is the Professional Review Organization responsible for conducting the Federally required utilization review of admissions and continued stays for each Medicaid recipient admitted to a mental hospital, or who becomes Medicaid-eligible while in the facility.

3. Pre-Admission Review

Mental hospital admissions must he prior authorized by PEERVIEW in order for the KMAP to reimburse the admitting facility. Prior to the proposed admission, a responsible person in the facility must contact the PEERVIEW office for pre-admission review. PEERVIEW has established a toll-free number (1-800-423-6512) for YMAP pre-admission reviews. This number will be answered Monday through Friday 8:00-5:30 Central time, 9:00-6:30 Eastern time. In case of weekend or emergency admissions, the facility must call the first working day following the admission.

Following a determination that the appropriate criteria have been met, PEERVIEW office staff will assign a pre-authorization number which the facility must enter in form locator #91 of the UB-82 billing form when the billing is submitted for KMAP payment.

4. The following information must be present in the medical records for each recipient for whom payment is requested:

a. Medicare Documentation

(1) A copy of the Medicare Remittance Advice or EOMB if the recipient has Medicare coverage for inpatient psychiatric services; a copy of the Medicare denial letters when applicable.

(2) If a recipient no longer qualifies for Medicare benefits prior to the exhaustion of the total number of days as specified by Medicare, a copy of the notification letter with the date for denial of Medicare reimbursement must be retained.

b. Utilization Review Documentation

(1) A copy of the admission Utilization Review performed for KMAP purposes and the date determined for the next review for continued stay; continued documentation of utilization reviews.

The responsibility of the Utilization Committee is to set forth regulations for concurrent review of the medical necessity and appropriateness of admissions and continued stays.

Each admission must be evaluated to assure that the admission to the facility is medically necessary and to insure the appropriateness of the admission. All admissions shall. be-reviewed within one working day following admission and assigned a specific date by which the continued stay will be reviewed.

(3) The committee or designee must review a recipient's continued stay on or before the expiration of each assigned continued stay review date.

Note: The Utilization Review process must be repeated for KMAP recipients; that is, an admission review must be performed at the time a patient is considered eligible for Medicaid coverage even though a previous admission review was done for Medicare.

c. Certification

A physician's statement documenting the necessity for the admission and/or continued stay must be provided in the medical records of each eligible recipient in a mental hospital.

This certification is the process whereby a physician attests in writing to an individual's need for psychiatric inpatient care. The certification must be provided on or not more than 60 days prior to admission to the institution; or when an individual makes application for Title XIX benefits while in an institution.

A licensed staff or consultant physician must sign or initial and date the certification. Other practitioner's signature or initials will not be accepted.

d. Recertification

Following the expiration of the initial certification (60 days from date of signature), if the patient requires further hospitalization and continues to meet the KMAP Title XIX requirements for continued hospitalization, a recertification is necessary.

Recertification is the process whereby the attending or consultant licensed physician attests in writing that the patient continues to require psychiatric inpatient care. This documentation must be signed or initialed and dated by the physician. Recertification is also valid for only a 60 day period, and therefore must be provided at least every sixty (60) days.

e. Plan of Care

A copy of the most recent plan of care established and approved by the patient's physician, including the date of the most recent interdisciplinary review or revision of the plan of care must be maintained in the patient file.

SECTION V - REIMBURSEMENT

V. REIMBURSEMENT

A. Cost Basis

The KMAP will pay for inpatient psychiatric services provided to eligible recipients in accordance with the reimbursement policies and procedures contained in the Cabinet for Human Resources, Title XIX Inpatient Hospital Reimbursement Manual and Supplement. If not otherwise specified, this system utilizes allowable cost principles of the Title XVIII (Medicare) Program.

B. Prospective Rates

Each participating mental hospital will be paid using a cost-related prospective payment rate based on the most recent available annual cost report data with costs trended to the beginning of the rate year and indexed for inflationary cost increases for the prospective rate year January 1 through December 31. The prospective rate will be all-inclusive, in that both routine and ancillary costs will be reimbursed through the rate.

If unaudited data is utilized to establish the rate, the rate will be revised when the audited cost report is received from the fiscal intermediary.

C. Conditions for Reimbursement

1. PRO/Utilization Review Documentation

The hospital must maintain information in each recipient's medical record which documents PEERVIEW's determination regarding admission and continued stay, the need for admission and/or continued stay, and assures appropriate utilization of services. For specific details, please refer to Section IV - Services Covered; E. Requirements for Inpatient Psychiatric Services.

2. The Notice of Availability of Income for Long Term Care (MAP-552)

a. MAP-552/L01 Process and Requirements

Before billing KMAP, the local office of the Department for Social Insurance (DSI) must initiate a Form MAP-552 after the patient status has been established in a mental health facility.

The Department for Social Insurance initiates action on the MAP-552 when they have received an Initial Certification for Long Term Care form (L01) from the PRO coordinator.

Upon receipt of the L01, the local DSI staff will conduct a financial investigation of the applicant/recipient and a determination will be made as to the amount of income that is to be considered as "available income" to be applied toward the cost of care.

The completed MAP-552 is sent to the Eligibility Verification Section of the KMAP who forwards a copy to the facility. Receipt of the MAP-552 is notification that the facility can bill KMAP for services provided to a Kentucky Medicaid recipient.

Since claims processed prior to entry into the system of continuing income data will reject, it is recommended that claims be submitted only after the MAP-552 is received by the mental hospital.

Whenever there is a change in the amount of the continuing income received by the recipient (either an increase or a decrease), a MAP-552 should be prepared by the Department for Social Insurance eligibility worker. Income data entered on the MAP-552 remains in effect until a new MAP-552 is issued.

b. Income Disregard Period

The recipient's income shall be disregarded through the month of admission when initially admitted to a mental health facility; however, for recipients in private pay status who become Title XIX eligible while in the facility, there shall be no income disregard period. The continuing income as indicated on the MAP-552, is to be collected by the facility from the recipient or responsible party, e.g. family, guardian or conservator. A direct transfer to another mental health facility would not begin another period of income disregard. If the recipient is out of vendor payment status for 30 days or more, the Department for Medicaid Services will allow a new income disregard period.

c. Collection of Continuing Income for Partial Month of Service

If a partial month of service is provided, the total amount of a recipient's available income is not to be collected. The computer will automatically prorate the recipient's available income and deduct that portion of the income available for collection for a partial month of service. The following formula will be used:

Days of Service x Pecipient's Available Income ÷ Days in Month = Amount to be Collected from Recipient or Applicable Income for that Portion of the Month.

Example:

10 days x $110.00 ÷ 30 days in month = 936.67

d. Children Committed to the Custody of the Department for Social Services

For payments to be made in a timely manner, the local Department for Social Insurance must he notified of the placement of children in a mental hospital by the Department for Social Services. If a MAP-552 has not been received within sixty (60) days after an LO1 has been issued by the PRO Coordinator, contact the Division of Family Services within the Department for Social Services. Questions concerning placement of children who are committed to the custody of the Department for Social Services may be addressed to the Director's Office of the Division of Family Services at (502) 564-5813.

D. Payment From Recipient

The KMAP requires all mental hospitals that participate in the Program to report all payments or deposits made toward a recipient's account, regardless of the source of payment. In the event that the hospital receives payment from an eligible KMAP recipient for a covered service, KMAP regulations preclude payment being made by the Program for that service unless documentation is received that the payment has been refunded. This policy does not apply to payments made by recipients for non-covered services.

E. Equal Charge

The charge made to KMAP should be the same charge made for comparable services provided to any party or payor.

F. Reimbursement to Out-of-State Facilities

The rate of reimbursement for covered psychiatric inpatient services provided by out-of-state providers will be set at seventy-five percent (75%) of usual and customary charges. Professional component services will be reimhursed at one hurdred percent (100%) of usual and customary charges.

G. Duplicate or Inappropriate Payments

Any duplicate or inappropriate payment by the KMAP, whether due to erroneous billing or payment system faults, must be refunded to the KMAP. Refund checks should be made payable to "Kentucky State Treasurer" and sent immediately, to:

EDS
P.O. Box 2009
Frankfort, KY 40602

ATTN: Cash/Finance Unit

Failure to refund a duplicate or inappropriate payment could be interpreted as fraud or abuse, and prosecuted as such.

H. Professional Component of Hospital-Based Physicians

Under the KMAP, hospital-based physicians are defined in the same manner as in Title XVIII Provider Reimbursement Manual, HIM-15, and may include all contract and/or salaried physicians.

1. A physician is considered a hospital-based physician when he or she enters into a contractual agreement with either a salary or percentage arrangement with the hospital to provide a service for patients. The cost of salary or contract must be recognized as a reimbursable cost before it can be reimbursed by the KMAP.

2. The KMAP will require that hospitals who bill for services provided its recipients by any or all of the hospital-based physicians maintain their records of payment on behalf of those physicians in such manner that the Program can obtain from hospital records exact information regarding amounts paid by the KMAP on behalf of each physician.

3. The KMAP will make payment to the hospital for the services of hospital-based physicians who have entered into financial agreements with the hospital for the purpose of providing services to patients of the hospital. This professional component payment will be included in the hospital's prospective rate of reimbursement. In order for the KMAP to make payment to the hospital in this manner, the hospital must obtain from the physician a completed "Kentucky Medical Assistance Program Statement of Authorization" (Form MAP-347, 8/82) as outlined in Section III B of this manual. Failure by providers to comply with this requirement when billing for professional component services could be interpreted as fraud or abuse.

4. Inpatient services provided to KMAP recipients by those hospital-based physicians meeting the above definition and filing the Statement of Authorization with the hospital, will be covered by the KMAP as long as the services are within the scope of the KMAP and the physician's contractual/financial arrangements with the hospital. These physicians cannot bill Medicaid for these services under any other Program element, and must have face-to-face contact with the recipient.

   This policy shall not preclude non-hospital-based physicians from billing for psychiatric services provided to eligible Medicaid recipients under the Physician's Program element of KMAP.

I. Days

1. For Medicaid purposes, a day is considered in relation to the midnight census.

2. Medicaid can pay the date of admission but cannot pay the date of discharge (death); however, ancillary charges incurred on the date of discharge (death) are KMPP allowable covered charges.

3. Recipients/responsible parties cannot be billed for the date of discharge (death).

J. Personal Items as a Component of Routine Costs

Patient convenience items (e.g. - toothpaste, toothbrushes, deodorants, paper tissues, mouthwashes, etc.) furnished routinely and relatively uniformly to all patients are considered part of routine services. These items are to be provided without cost to the recipient and are not billable to recipients/responsible parties.

VI. REIMBURSEMENT IN RELATION TO MEDICARE

A. Deductible and Coinsurance for Hospital Services

Part A Medicare

The Kentucky Medical Assistance Program will make payment on behalf of those Title XIX recipients who are al so entitled to benefits under Title XVIII, Part A of Public Law 89-97 for the inhospital deductible imposed under Title XVIII, Part A.

The KMAP will provide reimbursement for the recipient's Part A deductible and coinsurance days. Amounts due from KMAP will depend upon the benefit period as established by Medicare (Title XVIII). Amounts payable by KMAP for Part A services will be in accordance with amounts as listed on the Medicare Remittance Advice and/or EOMB. The coinsurance amount for the 61st-90th day is 1/4 of the applicable deductible amount. The KMAP elects not to make payment in accordance with Medicare provisions for lifetime reserve days due to the characteristics of the Medicaid prospective rates established for mental hospitals. Such days are not available under Medicare where average charges do not exceed one-half the inpatient hospital deductible amount, and are treated as non-covered days by Medicare. When payment could be appropriate for lifetime reserve days, Medicaid will make payment at the hospitals Medicaid established per diem rate. Payment for coinsurance days may be for a maximum of thirty (30) days. When these are exhausted, and the recipient is still hospitalized, the remaining days payable will be Title XIX.

Part B Medicare

The KMAP will also provide payment for the recipient's Title XVIII (Medicare) inpatient, Part B deductible and/or coinsurance of all allowed charges approved by Medicare; Amounts payable by Title XIX (Medicaid) will be the amounts listed on the Medicare Remittance Advice or EOMB.

SECTION VI - REIMBURSEMENT IN RELATION TO MEDICARE

When requesting payment for deductible and/or coinsurance days (Title XVIII, Part A) or deductible and/or coinsurance amounts (Title XVIII, Fart B) for inpatient services provided to recipients, the Medicare Remittance Advice or EOMB must be attached to the UB-82.

Amounts payable by KMAP will be reduced by amounts collected from other sources.

SECTION VII - REIMBURSEMENT IN RELATION TO THIRD PARTY COVERAGE
(EXCLUDING MEDICARE)

VII. REIMBURSEMENT IN RELATION TO THIRD PARTY COVERAGE (EXCLUDING MEDICARE)

A. General

To expedite the Medicaid claims processing payment function, the provider of Medicaid services must actively participate in the identification of third party resources for payment on behalf of the recipient. At the time the provider obtains Medicaid billing information from the recipient, he/she should determine if additional resources exist. Providers have an obligation to investigate and to report the existence of other insurance or liability by completing the TPL Lead Form and forwarding it to:

EDS
P.O. Box 2009
Frankfort, KY 40602
Attention: TPL Unit

The provider's cooperation will enable the Kentucky Medicaid Program to function more efficiently. Medicaid is the payor of last resort.

B. Identification of Third Party Resources

Pursuant to KRS 205.662, prior to billing the Kentucky Medical Assistance Program, all participating providers shall submit billings for medical services to a third party when such provider has prior knowledge that such third party may be liable for payment of the services.

In accordance with KRS 205.624, Medicaid recipients' right to third party payment is assigned to the Cabinet for Human Resources. Please refer to the reverse side of the recipient's Medical Assistance Identification Card for the recipient's assignment of benefits which state's : "You are hereby notified that under State Law, KRS 205.624, your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf."

SECTION VII - REIMBURSEMENT IN RELATION TO THIRD PARTY COVERAGE (EXCLUDING MEDICARE)

In order to identify those recipients who may be covered through a variety of health insurance resources, the provider should inquire if the recipient meets any of the following conditions: Is the recipient married or working? If so, inquire about possible health insurance through the recipient's or spouse's employer. If the recipient is a minor, ask about insurance the mother, father, or guardian may carry on the recipient. In cases of active or retired military personnel, request information about CHAMPUS coverage and social security number of the policy holder. For people over 65 or disabled, seek a Medicare number. Ask if the recipient has health insurance such as a Medicare Supplement policy, cancer, accident, or indemnity policy, group health or individual insurance, etc.

Examine the recipient's MAID card for an insurance code. If a code indicates insurance coverage, question the recipient further regarding the insurance.

Following is a list of the insurance codes on the MAID card:

A - Part A, Medicare only
Part B, Medicare only
; : Both Parts A and B Medicare
D - Blue Cross/Blue Shield
Blue Cross/Blue Shield/Major Medical
: : Private medical insurance
G - Champus
H - Health Maintenance Organization
J - Other and/or unknown
L - Absent Parent's insurance
M - None
United Mine Workers
; : Black Lung

SECTION VII - REIMBURSEMENT IN RELATION TO THIRD PARTY COVERAGE
(EXCLUDING MEDICARE)

C. Private Insurance

If the recipient has third party resources, then the provider must obtain payment or rejection from the third party before Medicaid can be billed. When payment is received, the provider should indicate on the claim form in the appropriate field the amount of the third party payment and the name and policy number(s) of health insurance covering the recipient. If the third party rejected the claim, a copy of the rejection notice must be attached to the Medicaid claim.

Exceptions:

*If the other insurance company has not respnnded within 120 days of the date a claim is submitted to the insurance company, submit with the Medicaid claim a copy of the other insurance claim indicating "NO RESPONSE" on the Medicaid claim form. Then forward a completed TPL Lead Form to:

EDS
P.O. Box 2009
Frankfort, KY 40602
Attn: TPL Unit

*If proof of denial for the same recipient for the same or related services from .the insurance company is attached to the Medicaid billing, claims processing can proceed. The denial cannot be more than six months old.

*A letter from the provider indicating that he/she contacted XYZ insurance company and spoke with an agent to verify that the recipient was not covered, can also be attached to the Medicaid claim.

SECTION VII - REIMBURSEMENT IN RELATION TO THIRD PARTY COVERAGE (EXCLUDING MEDICARE)

D. Medicaid Payment for Claims Involving a Third Party

If you have questions regarding third party payors, please contact:

EDS
Third Party Unit
P.O. Box 2009
Frankfort, KY 40602

(800) 372-2921
or
(502) 227-2525

Claims meeting the requirements for KMAP payment will be paid in the following manner if a third party payment is identified on the claim.

The amount paid by the third party will be applied to any non-covered days/services and any remaining monies will be deducted from the KMAP payment. If the third party payment amount exceeds the Medicaid allowed amount, the resulting KMAP payment will be zero. Recipients cannot be billed for any difference in covered charges and the Medicaid payment amount. All providers have the choice in determining if this type of service should be billed to the KMAP; however, if KMAP is billed for the service, the Program guidelines must be followed. When providers bill the KMAP, providers must accept Medicaid payment as payment in full.

If the claims for a recipient are payable by a third party resource which was not pursued by the provider, the claim will be denied. Along with a third party insurance denial explanation, the name and address of the insurance company, the name of the policy holder, and the policy number will be indicated. The provider must pursue payment with this third party resource before billing Medicaid again.

Itemized statements should be stamped "Medicaid Assigned" when they are forwarded to insurance companies, attorneys, recipients, etc.

SECTION VII - REIMBURSEMENT IN RELATION TO THIRD PARTY COVERAGE (EXCLUDING MEDICARE)

As a result of the passage of recent legislation, any time a Medicaid recipient requests an itemized bill and KMAP has made payment or has been billed for payment, the hospital must release the bill. Each page should be stamped indicating that the bill is for informational purposes only. In addition, the hospital should complete the TPL Lead Form and forward it to the KMAP.

E. Amounts Collected from Other Sources

1. If subsequent to billing KMAP, a provider receives monies for a service which, when added to KMAP's and all other payments for the service, creates an excess over the defined maximums, then that excess amount must be refunded to KMAP up to the total amount paid by KMAP. Refunds from state hospitals must be in the form of the appropriate inter-accounting notice to the KMAP and must clearly indicate the recipient's account to which it applies. Such refunds will routinely be adjusted on future checks to the facility unless a refund check is specifically requested by the KMAP. Refund checks should be made payable to the "Kentucky State Treasurer" and mail directly to: EDS, P.O. Box 2009, Frankfort, KY 40602, Attn: Cash/Finance.

2. When verification exists that the recipient has received monies from a liable third party for services paid by KMAP, the provider will be required to refund the full amount paid by KMAP and may seek total charges from the recipient. If the recipient did not receive enough monies to cover the total service, the provider may rebill KMAP, showing all amounts received from other sources.

F. Accident and Work Related Claims

For claims billed to KMAP that are related to an accident or work related incident, the provider should pursue information relating to the accident. If an attorney, employer, individual or an insurance company is liable for payment, payment must be pursued from the liable party. If the liable party has not been determined, attach copies of any information obtained, such as the names of attorneys, other involved parties and/or the recipient's employer to the claim when submitting to KMAP for Medicaid payment.

SECTION VIII - COMPLETION OF INVOICE FORM

VIII. COMPLETION OF INVOICE FORM

A. General

The UB-82 invoice must be used to bill for services provided in a mental hospital to eligible Medicaid recipients. Typing of this form is encouraged, since an invoice cannot be processed unless the information supplied is complete and legible. A copy of this form may be found in Appendix VIII of this manual.

Claims for covered mental hospital services provided to eligible recipients are required to be submitted monthly to KMAP. A full calendar month's billing is required unless the recipient is newly admitted to the facility during a portion of the month, is discharged, expires, or until authorization for benefit provisions is withdrawn by the PRO on the basis that further stay is not medically necessary. Providers may not split-bill for a month's service - i.e. - submit bills more frequently than a full calendar month (1st through 15th; 16th through 31st).

A separate UB-82 billing form is to be used for each recipient. The original UB-82 invoice must be submitted monthly to:

EDS
P.O. Box 2045
Frankfort, KY 40602

Under Federal Regulation (42 CFR 447.45) effective August 23, 1979, a requirement relating to timely submission of claims under Title XIX was added. Providers must submit claims within twelve (12) months of the date of service.

IMPORTANT: The recipient's Kentucky Medical Assistance Identification Card should be carefully checked to verify that the recipient's name appears on the card as an eligible recipient and that the card is valid for the dates of services to be provided. Services provided to an ineligible person are not reimbursable.

SECTION VIII - COMPLETION OF INVOICE FORM

B. Completion of UB-82 MEDICAID ONLY

Following are instructions in form locator order for billing Medicaid services on the UB-82 billing statement (completion of UB-82 for Medicare/Medicaid coinsurance and/or deductible is found in Section VIII C of this manual). Only instructions for form locators required for EDS processing or KMAP information are included. Instructions for form locators not used by EDS/KMAP processing may be found in the UB-82 Training Manual. The UB-82 Training Manual may be obtained from the Kentucky Hospital Association.

Form Locator

1 PROVIDER NAME AND ADDRESS

Enter the complete name and address of the facility. The telephone number including area code, is desired.

3 PATIENT CONTROL NUMBER

Enter the patient control number. The first 7 digits will appear on the Remittance Advice.

4 TYPE OF BILL

Enter the applicable 3 digit code that describes type of bill.

1st Digit (Type Facility): 1 = Hospital

2nd Digit (Bill Class):
1 = Inpatient (includes Medicare Part A)
2 = Inpatient (Medicare Part B only)

3rd Digit (Frequency):
1 = Admit through discharge claim
2 = Interim Billing (First Claim)
3 = Interim Billing (Continuing Claim)
4 = Interim Billing (Last Claim)

SECTION VIII - COMPLETION OF INVOICE FORM

Form Locator

8 MEDICAID PROVIDER NUMBER

Enter the facility's 8-digit Kentucky Medicaid Provider number.

10 PATIENT NAME

Enter the name of the recipient in-last name/first name sequence as shown on his/her current Medical Assistance Identification (MAID) card.

15 DATE OF ADMISSION

Enter the date on which the recipient was admitted to the facility in month, day, year sequence and in numeric format (e.g., 01/03/86).

21 PATIENT STATUS CODE

Enter the applicable 3 digit patient status code (a list of the codes and descriptions are found in Section II of the UB-82 manual).

22 STATEMENT COVERS PERIOD

From - Enter the beginning date of the billing period covered by this invoice in month, day, year sequence and in numeric format.

Through - Enter the last date of the billing period covered by this invoice in month, day, year sequence and in numeric format (must be the same calendar month as the from date).

23 COVERED DAYS

Enter the number of days during the billing month that the recipient was actually in the facility. (Do not bill for the day on which the recipient was temporarily discharged.) Data entered in Form Locator 23 must agree with accommodation units entered in Form Locator 52.

SECTION VIII - COMPLETION OF INVOICE FORM

Form Locator

24 NON-COVERED DAYS

Enter the number of days during the billing month that the recipient was temporarily out of the facility (e.g. home leave, etc.).

28 OCCURRENCE

Required for final bill if date of discharge is different from the through date (#22). Enter code 42 (discharge) and the discharge date.

50 DESCRIPTION

Enter the UB-82 standard abbreviation corresponding to the appropriate 3-digit revenue code for room, board, and ancillary charges.

DAILY ROOM CHARGE

Enter the facility's usual and customary per diem room charge.

51 REVENUE CODE

Enter the 3 digit revenue code for the Room, Board, or Ancillary service being billed (A LIST OF THE REVENUE CODES ACCEPTED BY KMAP CAN BE FOUND IN APPENDIX XVI). Revenue code 001 (Total Charges) must be the last revenue code listed.

52 UNITS

Enter the number of days/units (if more than 1) for each service billed.

53 TOTAL CHARGES

Enter the line charges for services provided within days being billed to KMAP. (DAYS/UNITS X PER DIEM/PER UNIT CHARGE = LINE CHARGE).' The total covered charges must be listed on a line corresponding with revenue code 001 (Total Charges).

SECTION VIII - COMPLETION OF INVOICE-FORM

Form Locator

57 PAYER

Enter the name of each payer (e.g. Medicaid, Private Insurance, etc.) from which the provider might expect payment.

63 PRIOR PAYMENTS

Enter the total amount (if any) received from private insurance (the amount should be listed on the corresponding line with the payer in form locator #57). Neither Medicare payment amount, Medicaid payment amount, nor the recipient continuing income amount is to be entered.

65 INSURED'S NAME

Enter the name of the recipient in last name/first name sequence as shown on his/her current MAID card.

68 MEDICAL ASSISTANCE ID NUMBER

Enter the recipient's 10 digit identification number exactly as shown on his/her current MAID card.

77 PRINCIPAL DIAGNOSIS CODE

Enter the ICD-9-CM diagnosis code for which the recipient is receiving treatment.

78 THRU 81 OTHER DIAGNOSIS CODES

Enter other ICD-9-CM diagnosis codes (if any) for which the recipient is receiving treatment.

SECTION VIII - COMPLETION OF INVOICE FORM

C. Medicare/Medicaid Coinsurance and/or Deductible

When submitting claims to KMAP/EDS for Medicare coinsurance and/or deductible, a UB-82 should be completed according to the instructions shown in Section VIII B of this manual with the following additions:

1. The Medicare deductible amount (if any) due from Medicaid should be entered in form locator #60 (Deductible) on the corresponding line (a, b, or c) listing Medicare as a payer (form locator #57).

2. The Medicare coinsurance days (if any) billed to Medicaid should be entered in form locator #25 (coinsurance days). The Medicare coinsurance amount (if any) due from Medicaid should be entered in form locator #61 (Coinsurance) on the corresponding line (a, b, or c) listing Medicare as a payer (form locator P57).

A copy of the corresponding Medicare Remittance Advice MUST be attached to the UB-82.

SECTION IX - REMITTANCE STATEMENT

IX. REMITTANCE STATEMENT

A. General

The EDS Remittance Statement (Remittance Advice) furnishes the provider with an explanation of the status of those claims EDS processed. The Remittance Statement accompanies the payment check and is divided into six sections.

The first section provides an accounting of those claims which are being paid by the KMAP with the accompanying payment check.

The second section provides a list of claims which have been rejected (denied) in total by the KMAP with the corresponding Explanation of Eenefit (EOB) code.

The third section provides a list of claims EDS received which did not complete processing as of the date indicated on the Remittance Statement.

The fourth section provides a list of claims received by EDS that could not be processed as the result of incomplete claim information. These claims have been returned to the provider along with a cover letter that explains the reasons for the return.

The fifth section includes the summation of claims payment activity as of the date indicated on the Remittance Statement and the year-to-date claims payment activities.

The sixth section provides a list of the EOB codes which appeared on the dated Remittance Statement with the corresponding written explanation of each EOB code.

Claims appearing in any section of the Remittance Statement will be in alphabetical order according to the patient's last name.

SECTION IX - REMITTANCE STATEMENT

B. Medicare Deductibles and Coinsurance

The explanation of payment for any Medicare deductibles and coinsurance will appear on a separate page from regular KMAP claims and in a slightly different format. The provider should bill the Medicare Program for any Medicare covered services rendered to recipients over 65 and other eligible persons (the disabled and the blind). The Medicare Program does not cover the patient's deductible and coinsurance amounts, but the KMAP will make payment of these amounts for KMAP eligible recipients.

C. Section I - Claims Paid

An example of the first section of the Remittance Statement is shown in Appendix IX P.1. This section lists all of those claims for which payment is being made. On the page immediately following are item-by-item explanations of each individual entry appearing on this section of the Remittance Statement.

EXPLANATION OF REMITTANCE STATEMENT
FOR MENTAL HOSPITAL SERVICES

ITEM	
INVOICE NUMBER	The preprinted invoice number (or patient account number) appearing on each claim form is printed in this column for the provider's reference
RECIPIENT NAME	The name of the recipient as it appears on the Department's file of eligible Medicaid recipients
RECIPIENT NUMBER	The Medical Assistance I.D. Number of the recipient as shown on the claim form submitted by the provider
INTERNAL CONTROL NO.	The internal control number (ICN) assigned to the claim for identification purposes by EDS

SECTION IX - REMITTANCE STATEMENT

DATES OF SERVICES.	The earliest and latest dates of service as shown on the claim form
TOTAL CHARGES	The total charges billed by the provider for the services on this claim form
PROFESSIONAL COMPONENT	That portion of the charges billed by the provider that represents the professional component payable by the Program
AMT. FROM OTHER SRCS	The amount indicated by the provider as received from a source other than the Medicaid Program for services on the claim
CLAIM PMT AMOUNT	The amount being paid by the Medicaid Program to the provider for this claim
EOB	For explanation of benefit code, see back page of Remittance Statement
ACCOM/ANCIL	The accommodation and ancillary charges in Form Locator 53 of' the UB-82
QTY	The number of procedures/supply for that line item charge
LINE NO.	The number of the line on the claim being printed
LINE ITEM CHARGE	The charge submitted by the provider for the procedure in the line item
LINE ITEM PMT	The amount being paid by the Medicaid Program to the provider for a particular line item
PROF COMP	That portion of the charges billed by the provider that represents the professional component payable by the program for that line item
EOB	Explanation of benefit code which identifies the payment process used to pay the line item

D. Section II - Denied Claims

The second section of the Remittance Statement appears whenever one or more claims are rejected in total. This section lists ail such claims and indicates the EOB code expiaining the reason for each claim rejection. (Appendix IX Page 2)

All items printed have been previously defined in the descriptions of the paid claims section of the Remittance Statement.

E. Section III - Claims in Process

The third section of the Remittance Statement (Appendix IX Page 3) lists those claims which have been received by ECS but which were not adjudicated as of the date of this report. A claim in this category usually has been suspended from the normal processing cycle because of data errors or the need for further review. A claim only appears in the Claims In Process section of the Remittance Statement as long as it remains in process. At the time a final determination can be made as to claim disposition (payment or rejection) the claim will appear in Section I or II of the Remittance Statement.

F. Section IV - Returned Claims

The fourth section of the Remittance Statements (Appendix IX Page 4) lists those claims which have been received by ECS and returned to the provider because required information is missing from the claim. The claim has been returned to the provider with a cover sheet which indicates the reason(s) that the claim has been returned.

G. Section V - Claims Payment Summary

This section is a summary of the claims payment activities as of the date indicated on the Remittance Statement and the year-to-date (YTD) claims payment activities.

CLAIMS PAID/DENIED	the total number of finalized claims which have been determined to be denied or paid by the Medicaid Program, as of the date indicated on the Remittance Statement and YTD summation of claim activity
AMOUNT PAID	the total amount of claims that paid as of the date on the Remittance Statement and the YTD summation of payment activity
WITHHELD AMOUNT	the dollar amount that has been recouped by Medicaid as of the date on the Remittance Statement (and YTD summation of recouped monies)
NET PAY AMOUNT	the dollar amount that appears on the check
CREDIT AMOUNT	the dollar amount of a refund that a provider has sent in to EDS to adjust the 1099 amount (this amount does not affect claims payment, it only adjusts the 1099 amount)
NET 1099 AMOUNT	the total amount of money that the provider has received from the Medicaid Program as of the date on the Remittance Statement and the YTD total monies received taking into consideration recoupments and refunds

H. Section VI - Description of Explanation Codes Listed Above

Each EOB code that appeared on the dated Remittance Statement will have a corresponding written explanation pertaining to payment, denial, suspension and return for a particular claim (Appendix IX Page 5).

SECTION X - GENERAL INFORMATION - EDS

A. Correspondence Forms Instructions

Type of Information Requested	Time Frame for Inquiry	Mailing Address
Inquiry	6 weeks after billing	EDS P.O. box 2009 Frankfort, KY 40602 ATTN: Communications Unit
Adjustment	Immediately	EDS P.O. Box 2009 Frankfort, KY 40602 ATTN: Adjustments Unit
Refund	Immediately	EDS P.O. Box 2009 Frankfort, KY 40602 ATTN: Cash/Finance Unit

Type of Information Requested	Necessary Information
Inquiry	1. Completed Inquiry Form 2. Remittance Advice or Medicare EOMB, when applicable 3. Other supportive documentation, when needed, such as a photocopy of the Medicaid claim when a claim has not appeared on an R/A within a reasonable amount of time

Type of Information Requested	Necessary Information
Adjustment	1. Completed Adjustment Form 2. Photocopy of the claim in question 3. Photocopy of the applicable portion of the R/A in question
Refund	1. Refund Check 2. Photocopy of the applicable portion of the R/A in question 3. Reason for refund

B. Telephoned Inquiry Information

What is Needed?

- Provider number
- Patient's Medicaid ID number
- Date of service
- Billed amount
- Your name and telephone number

When to Call?

- When claim is not showing on paid, In process or denied sections of the R/A within 6 weeks
- When the status of claims are needed and they do not exceed five in number

Where to Call?

- Toll-free number i-800-372-2921 (within Kentucky)
- Local (502) 227-2525

C. Filing Limitations

New Claims	12 months from date of service
Medicare/Medicaid Crossover Claims	12 months from date of service
	NOTE: If the claim is a Medicare crossover claim and is received by EDS more than 12 months from date of service, but less than 6 months from the Medicare adjudication date, EDS considers the claim to be within the filing limitations and will proceed with claims processing.
Third-Party Liability Claims	12 months from date of service
	NOTE: If the other insurance company has not responded within 120 days of the date a claim is submitted to the insurance company, submit the claim to EDS indicating "NO RESPONSE" from the other insurance company.
Adjustments	12 months from date the paid claim appeared on the R/A

D. Provider Inquiry Form

The Provider Inquiry form should be used for inquiries to EDS regarding paid or denied claims, billing concerns, and-claim status. (If requesting more than one claim status, a Provider Inquiry form should be completed for each status request.) The Provider Inquiry Form should be completed in its entirety and mailed to the following address:

EDS
P.O. Box 2009
Frankfort, KY 40602

Supplies of the Provider Inquiry form may be obtained by writing to the above address or contacting EGS Provider Relations Unit at 1-(800)-372-2921 or 1-(502)-227-2525.

Please remit both copies of the Provider Inquiry form to EDS. Any additional documentation that would help clarify your inquiry should be attached. EDS will enter their response on the form and the yellow copy will be returned to the provider.

It is not necessary to complete a Provider Inquiry form when resubmitting a denied claim.

Provider Inquiry forms may not be used in lieu of KMAP claim forms, Adjustment forms, or any other document required by KMAP.

In certain cases it may be necessary to return the inquiry form to the provider for additional information if the inquiry is illegible or unclear.

Instructions for completing the Provider Inquiry form are found on the next page.

SECTION X - GENERAL INFORMATION - EDS

Following are field by field instructions for completing the Provider Inquiry form:

Field Number	Instructions
1	Enter your 8-digit Kentucky Medicaid Provider Number.
2	Enter your Provider Name and Address.
3	Enter the Medicaid Recipient's Name as it appears on the Medical Assistance I.D. Card.
4	Enter the recipient's 10 digit Medical Assistance ID number.
5	Enter the Billed Amount of the claim on which you are inquiring.
6	Enter the Claim Service Date(s).
7	If you are inquiring in regard to an in-process, paid, or denied claim, enter the date of the Remittance Advice listing the claim.
8	If you are inquiring in regard to an in-process, paid, or denied claim, enter the 13 digit internal control number listed on the Remittance Advice for that particular claim.
9	Enter your specific inquiry.
10	Enter your signature and date of the inquiry.

E. Adjustment Request Form

The Adjustment Request form is to be used when requesting a change on a previously paid claim. This does not include denied claims or claims returned to the provider for requested additional information or documentation.

For prompt action and response to the adjustment requests, please complete all items. COPIES OF THE CLAIM AND THE APPROPRIATE PAGE OF THE R/A MUST BE ATTACHED TO THE ADJUSTMENT REQUEST FORM. If items are not completed, the form may be returned.

Field Number	Description
1	Enter the 13-digit claim number for the particular claim in question.
2	Enter the recipient's name as it appears on the R/A (last name first).
3	Enter the complete recipient identification number as it appears on the R/A. The complete Medicaid number contains 10 digits.
4	Enter the provider's name, address and complete provider number.
5	Enter the "From Date of Service" for the claim in question.
6	Enter the "To Date of Service" for the claim in question.
7	Enter the total charges submitted on the original claim.

Field Number	Description
8	Enter the total Medicaid payment for the claim as found under the "Claims payment Amount" column on the R/A.
9	Enter the R/A date which is found on the top left corner of the remittance. Please do not enter the date the payment was received or posted.
10	Specifically state WHAT is to be adjusted on the claim (i.e. date of service, units of service).
11	Specifically state the reasons for the request adjustment (i.e. misccded, overpaid, underpaid).
12	Enter the name of the person who completed the Adjustment Request Form.
13	Enter the date on which the form was submitted.

Mail the completed Adjustment Request form, claim copy and Remittance Advice to the address on the top of the form.

To reorder these forms, contact the Provider Relations Unit by mail:

EDS
P.O. Box 2009
Frankfort, KY 40602

Be sure to specify the number of forms you desire. Allow 7 days for delivery.

MENTAL HOSPITALS

APPENDIX

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

Ambulatory Surgical Center Services

Medicaid covers medically necessary services performed in ambulatory surgical centers.

Birthing Center Services

Covered birthing center services include an initial prenatal visit, follow-up prenatal visits, delivery and up to two follow-up postnatal visits within 4-6 weeks of the delivery date.

Dental Services

Coverage is limited but includes X-rays, filiings, simple extractions, and emergency treatment for pain, infection and hemorrhage. Preventive dental care is stressed for individuals under age 21.

Family Planning Services

Comprehensive family planning services are available to all eligible Title XIX recipients of childbearing age and those minors who can be considered sexually active. These services are offered through participating agencies such as local county health departments and independent agencies, i.e., Planned Parenthood Centers. Services are also available through private physicians.

A complete physical examination, counseling, contraceptive education and educational materials, as well as the prescribing of the appropriate contraceptive method, are available through the Family Planning Services element of the KMAP. Follow-up visits and emergency treatments are also provided.

Hearing Services

Hearing evaluations and single hearing aids, when indicated, are paid for by the program for eligible recipients, to the age of 21. Follow-up visits, as well as check-up visits, are covered through the hearing services element. Certain hearing aid repairs are also paid through the program.

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

Home Health Services

Skilled nursing services, physical therapy, speech therapy, occupational therapy and aide services are covered when necessary to help the patient remain at home. Medical social worker services are covered when provided as part of these services. Home Health coverage also includes disposable medical supplies; and durable medical equipment, appliances and certain prosthetic devices on a preauthorited basis. Coverage for home health services is not limited by age.

Hospital Services

Inpatient Services

KMAP benefits include reimbursement for admissions to acute care hospitals for the manaaement of an acute illness, an acute phase or complications of a chronic illness, injury, impairment, necessary diagnostic procedures, maternity care, and acute psychiatric care. All non-emergency hospital admissions must be preauthorized by a Peer Review Organization. Certain surgical procedures are not covered on an inpatient basis, except when a life-threatening situation exists, there is another primary purpose for admission, or the physician certifies a medical necessity requiring admission to the hospital. Elective and cosmetic procedures are outside the scope of program benefits unless medically necessary or indicated. Reimbursement is limited to a maximum of fourteen (14) days per admission.

Outpatient Services

Benefits of this program element include diagnostic, therapeutic, surgical and radiological services as ordered by a physician; clinic visits, selected biological and blood constituents, emergency room services in emergency situations as determined by a physician; and services of hospital-based emergency room physicians.

There are no limitations on the number of hospital outpatient visits or services available to program recipients.

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

Laboratory Services

The following laboratory tests are covered when ordered by a physician and done in a laboratory certified by the Department of Health and Human Services:

Cultures (Screening)
Blood Culture (definitive)
Stool (Ova and parasites)
Smears for Bacteria, Stained
Bilirubin
Bleeding Time
Red Blood Count
Hemoglobin
White Blood Count
Differential
Complete Blood Count
Cholesterol
Clotting Time
Hematocrit
RA Test (Latex Agglutinations)
Acid Phosphatase
Alkaline Phosphatase
Potassium
Prothrombin Time
Sedimentation Rate
Uric Acid
Stool (Occult Blood)
Pap Smear
Urine Analysis
Urine Culture
Sensitivity Testing
Pregnancy Test
CPK/Creatine
Thyroid Profile
T3
T4
Glucose Tolerance
Electrolytes
Dilantin/Phenobarbital/Drug Abuse Screen
Arthritis Profile
VDRL
Glucose (Blood)
SGOT or SGPT (Serum Transaminase)
Blood Typing
Blood Urea Nitrogen
Sodium
Any 3 *or More* Automated Tests
Rubella
Therapeutic Drug Monitoring
Lithium
Theophylline
Digoxin
Digitoxn

Long-Term Care Facility Services

Skilled Nursing Facility Services

The KMAP can make payment to skilled nursing facilities for:

A. Services provided to Medicaid recipients who require twenty-four (24) skilled nursing care and/or skilled services which as a practical matter can only be provided on an inpatient basis.*

B. Services provided to recipients who are also medically eligible for Medicare benefits in the skilled nursing facility.

-Coinsurance from the 21st through the 100th day of this Medicare benefit period.
-Full cost for the full length of stay after the 100th day if 24-hour skilled nursing care is still required.*

*Need for skilled nursing care must be certified by a Peer Review Organization (PRO).

Intermediate Care Facility Services

The KMAP can make payment to intermediate care facilities for:

A. Services provided to recipients who require intermittent skilled nursing care and continuous personal care supervision.*

B. Services provided to Medicaid recipients who are mentally retarded or developmentally disabled prior to age 22, who because of their mental and physical condition require care and services which are not provided by community resources.**

*Need for the intermediate level of care must be certified by a PRO.

**Need for the ICF/MR/DD level of care must be certified by a PRO.

Mental Hospital Services

Inpatient psychiatric services are provided to Medicaid recipients under the age of 21 and age 65 or older in a psychiatric hospital. There is no limit on length of stay; however, the need for inpatient psychiatric hospital services must be verified through the utilization control mechanism.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

Community Mental Health Center Services

Community mental health-mental retardation centers serve recipients of all ages in the community setting. From the center a patient may receive treatment through:

Outpatient Services
Partial Hospitalization
Emergency Services
Inpatient Services
Personal Care Home Visits

Eligible Medicaid recipients needing psychiatric treatment, may receive services from the community mental health center and possibly avoid hospitalization. There are fourteen (14) major centers, with many satellite centers available. Kentucky Medical Assistance Program reimburses private practicing psychiatrists for psychiatric services through the physician program.

Nurse Anesthetist Services

Anesthesia services performed by a participating Advanced Registered Nurse Practitioner - Nurse Anesthetist are covered by the KMAP.

Nurse Midwife Services

Medicaid coverage is available for services performed by a participating Advanced Registered Nurse Practitioner - Nurse Midwife. Covered services include an initial prenatal visit, follow-up prenatal visits, delivery and up to two follow-up post partum visits within 4 to 6 weeks of the delivery date.

Pharmacy Services

Legend and non-legend drugs from the' approved Medical Assistance Drug List when required in the treatment of chronic and acute illnesses are covered by the KMAP. The Department is advised regarding the outpatient drug coverage by a formulary subcommittee composed of persons from the medical and pharmacy professions. A Drug List is available to individual pharmacists and physicians upon request and routinely sent to participating pharmacies and long-term care facilities. The Drug List is distributed quarterly with monthly updates.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

Pharmacy Services (Continued)

In addition, certain other drugs which may enable a patient to be treated on an outpatient basis and avoid institutionalization are covered for payment through the Drug Preauthorization Program.

Physician Services

Covered services include:

Office visits, medically-indicated surgeries, elective sterilizations*, deliveries, chemotherapy, radiology services, emergency room care, anesthesiology services, hysterectomy procedures*, consultations, second opinions prior to surgery, assistant surgeon services, oral surgeon services, psychiatric services.

*Appropriate consent forms must be completed prior to coverage of these procedures.

Non-covered services include:

Injections, immunizations, supplies, drugs (except anti-neoplastic drugs), cosmetic procedures, package obstetrical care, IUDs, diaphragms, prosthetics, various administrative services, miscellaneous studies, post mortem examinations, surgery not medically necessary or indicated.

Limited coverage:

One comprehensive office visit per twelve (12) month period, per patient, per physician.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

Physician Services (Continued)

The following laboratory procedures are covered when performed in the office by an M.D. or osteopath.

Ova and Parasites (feces)
Smear for Bacteria, stained
Throat Cultures (Screening)
Red Blood Count
Hemoglobin
White Blood Count
Differential Count
Bleeding Time
Electrolytes
Glucose Tolerance
Skin Tests for:
- Histoplasmosis
- Tuberculosis
- Coccidioidomycosis
- Mumps
- Brucella

Complete Blood Count
Hematocrit
Prothrombin Time
Sedimentation Rate
Glucose (Blood)
Blood Urea Nitrogen (BUN)
Uric Acid
Thyroid Profile
Platelet count
Urine Analysis
Creatinine

Bone Marrow spear and/or cell block; aspiration only
Smear; interpretation only
Aspiration; staining and interpretation
Aspiration and staining only
Bone Marrow needle biopsy
Staining and interpretation
Interpretation only
Fine needle aspiration with or without preparation of smear; superficial tissue
Deep tissue with radiological guidance
Evaluation of fine needle aspirate with or without preparation of smears
Duodenal intubation and aspiration: single specimen
Multiple specimens
Gastric intubation and aspiration: diagnostic
Nasal smears for eospinophils
Sputum, obtaining specimen, aerosol induced technique

Podiatry Services

Selected services provided by licensed podiatrists are covered by the Kentucky Medical Assistance Program. Routine foot care is covered only for certain medical conditions where such care requires professional supervision.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

Primary Care Services

A primary care center is a comprehensive ambulatory health care facility which emphasizes preventive and maintenance health care. Covered outpatient services provided by licensed, participating primary care centers include medical services rendered by advanced registered nurse practitioners as well as physician, dental and optometric services, family planning, EPSDT, laboratory and radiology procedures, pharmacy, nutritional counseling, social services and health education. Any limitations applicable to individual program benefits are generally applicable when the services are provided by a primary care center.

Renal Dialysis Center Services

Renal service benefits include renal dialysis, certain supplies and home equipment.

Rural Health Clinic Services

Rural health clinics are ambulatory health care facilities located in rural, medically underserved areas. The program emphasizes preventive and maintenance health care for people of all ages. The clinics, though physician directed, must also be staffed by Advanced Registered Nurse Practitioners. The concept of rural health clinics is the utilization of mid-level practitioners to provide quality health care in areas where there are few physicians. Covered services include basic diagnostic and therapeutic services, basic laboratory services, emergency services, services provided through agreement or arrangements, visiting nurse services and other ambulatory services.

Screening Services

Through the screening service element, eligible recipients, age 0-thru birth month of 21st birthday, may receive the following tests and procedures as appropriate for age and health history when provided by participating providers:

- Medical History
- Physical Assessment
- Growth and Developmental Assessment
- Screening for Urinary Problems
- Screening for Hearing and Vision Problems
- Tuberculin Skin Test
- Dental Screening
- Screening for Veneral Disease, As Indicated
- Assessment and/or Updating of Immunizations

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

Transportation Services

Medicaid may cover transportation to and from Title XIX-covered medical services by ambulance or other approved vehicle if the patient's condition requires special transportation. Also covered is preauthorized non-emergency medical transportation to physicians and other non-emergency, Medicaid-covered medical services. Travel to pharmacies is not covered.

Vision Services

Examinations and certain diagnostic procedures performed by ophthalmologists and optometrists are covered for recipients of all ages. Professional dispensing services, lenses, frames and repairs are covered for persons under age 21.

SPECIAL PROGRAMS

KenPAC: The Kentucky Patient Access and Care System, or KenPAC, is a special program which links the recipient with a primary physician or clinic for many Medicaid-covered services. Only recipients who receive assistance based on Aid to Families with Dependent Children (AFDC) or AFDC-related Medical Assistance Only are covered under KenPAC. The recipient may choose the physician or clinic. It is especially important for the KenPAC recipient to present his/her Medical Assistance Identification Card each time a service is received.

AIS/MR: The Alternative Intermediate Services/Mental Retardation (AIS/MR) home- and community-based services project provides coverage for an array of community based services that is an alternative to receiving the services in an intermediate care facility for the mentally retarded and developmentally disabled (ICF/MR/DD). Community mental health centers arrange for and provide these services.

HCB: A home- and community-based services project provides Medicaid coverage for a broad array of home- and community-based services for elderly and disabled recipients. These services are available to recipients who would otherwise require the services in a skilled nursing facility (SNF) or intermediate care facility (ICF). The services were statewide July 1, 1987. These services are arranged for and provided by home health agencies.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

HOSPICE:

Medicaid benefits include reimbursement for hospice care for Medicaid clients who meet the eligibility criteria for hospice care. Hospice care provides to the terminally ill relief of pain and symptoms. Supportive services and assistance are also provided to the patient and his/her family in adjustment to the patient's illness and death. A Medicaid client who elects to receive hospice care waives a?? rights to certain Medicaid services which are included in the hospice care scope of benefits.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

MENTAL HOSPITAL SERVICES MANUAL

ELIGIBILITY INFORMATION

Programs

The Department for Social Insurance, Division of Field Services local office staff have primary responsibility for accepting and processing applications for benefit programs administered by the Cabinet for Human Resources, Department for Social Insurance. These programs, which include eligibility for Medicaid, include:

AFDC (Aid to Families with Dependent Children)

AFDC Related Medical Assistance

State Supplementation of the Aged, Blind, or Disabled

Aged, Blind, or Disabled Medical Assistance

Refugee Resettlement Programs

Any individual has the right to apply for Medicaid and have eligibility determined. Persons wanting to apply for Medicaid benefits should be referred to the local Department for Social Insurance, Division of Field Services office in the county in which they live. Persons unable to visit the local office may write or telephone the local office for information about making application. For most programs, a relative or other interested party may make application for a person unable to visit the office.

In addition to the programs administered by the Department for Social Insurance, persons eligible for the federally administered Supplemental Security Income (SSI) program also receive Medicaid through the Kentucky Medical Assistance Program. Eligibility for SSI is determined by the Social Security Administration. Persons wanting to apply for SSI should be referred to the Social Security Administration office nearest to the county in which they live. The SSI program provides benefits to individuals who meet the federal definitions of age, blindness, or disability, in addition to other eligibility requirements.

ELIGIBILITY INFORMATION

MAID Cards

Medical Assistance Identification (MAID) cards are issued monthly to recipients with ongoing eligibility. These cards show a month-to-month eligibility period.

Eligible individuals with excess income for ongoing eligibility may be eligible as a "spend down" case if incurred medical expenses exceed the excess income amount. Individuals eligible as a "spend down" case receive one MAID card indicating the specific period of eligibility. After this eligibility period ends, the person may reapply for another "spend down" eligibility period.

MAID cards may show a retroactive period of eligibility. Depending on the individual circumstances of eligibility, the retroactive period may include several months.

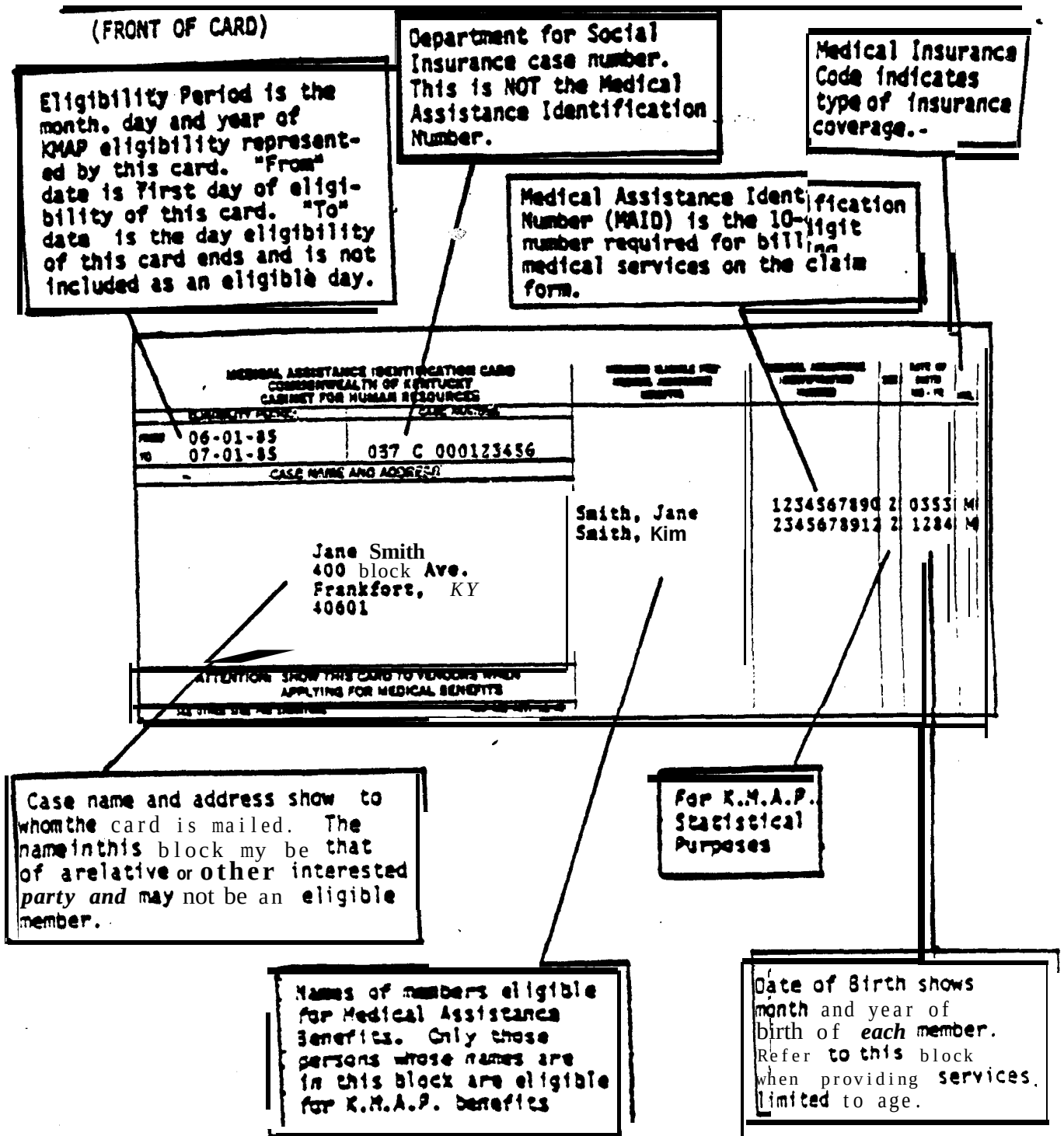
Duplicate MAID cards may be issued for individuals whose original card is lost or stoien. The recipient should report the lost or stolen card to the local Department for Social Insurance, Division of Field Services worker responsible for the case.

Verifying Eligibility

The local Department for Social Insurance, Division of Field Services staff may provide eligibility information to providers requesting MAID numbers and eligibility dates for active, inactive or pending cases.

The Department for Medicaid Services, Eligibility Services Section at (502) 564-6885 may also verify eligibility for providers.

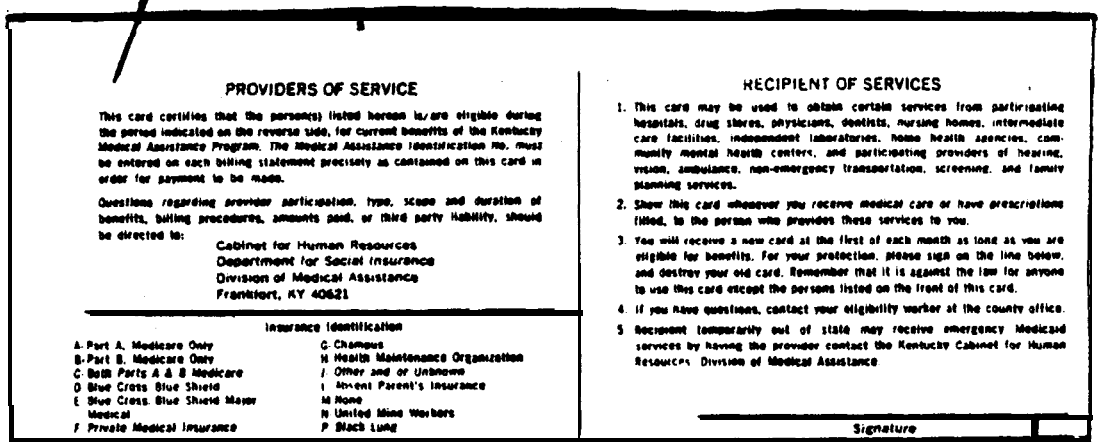
KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD



KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD

(BACK OF CARD)

Information to Providers. Insurance Identification codes indicate type of insurance coverage as shown on the front of the card in "Ins" block.



PROVIDERS OF SERVICE

This card certifies that the person(s) listed hereon is/are eligible during the period indicated on the reverse side, for current benefits of the Kentucky Medical Assistance Program. The Medical Assistance Identification No. must be entered on each billing statement precisely as contained on this card in order for payment to be made.

Questions regarding provider participation, type, scope and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to:

Cabinet for Human Resources
Department for Social Insurance
Division of Medical Assistance
Frankfort, KY 40621

Insurance Identification

A- Part A, Medicare Only
B- Part B, Medicare Only
C- Both Parts A & B Medicare
D Blue Cross Blue Shield
E Blue Cross Blue Shield Major Medical
F Private Medical Insurance
G Champus
H Health Maintenance Organization
I Other and or Unknown
J Absent Parent's Insurance
M None
N United Mine Workers
P Black Lung

RECIPIENT OF SERVICES

1. This card may be used to obtain certain services from participating hospitals, drug stores, physicians, dentists, nursing homes, intermediate care facilities, independent laboratories, home health agencies, community mental health centers, and participating providers of hearing, vision, ambulance, non-emergency transportation, screening, and family planning services.
2. Show this card whenever you receive medical care or have prescriptions filled, to the person who provides these services to you.
3. You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection, please sign on the line below, and destroy your old card. Remember that it is against the law for anyone to use this card except the persons listed on the front of this card.
4. If you have questions, contact your eligibility worker at the county office.
5. Recipient temporarily out of state may receive emergency Medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Division of Medical Assistance.

Signature

RECIPIENT OF SERVICES: You are hereby notified that under State Law, KRS 205.624, your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.

Federal law provides for a $10,000 fine or imprisonment for a year, or both, for anyone who willfully gives false information in applying for medical assistance, fails to report changes relating to eligibility, or permits use of the card by an ineligible person.

Notification to recipient of assignment to the Cabinet for Human Resources of third party payments.

Recipient's signature is not required.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

MENTAL HOSPITAL SERVICES MANUAL

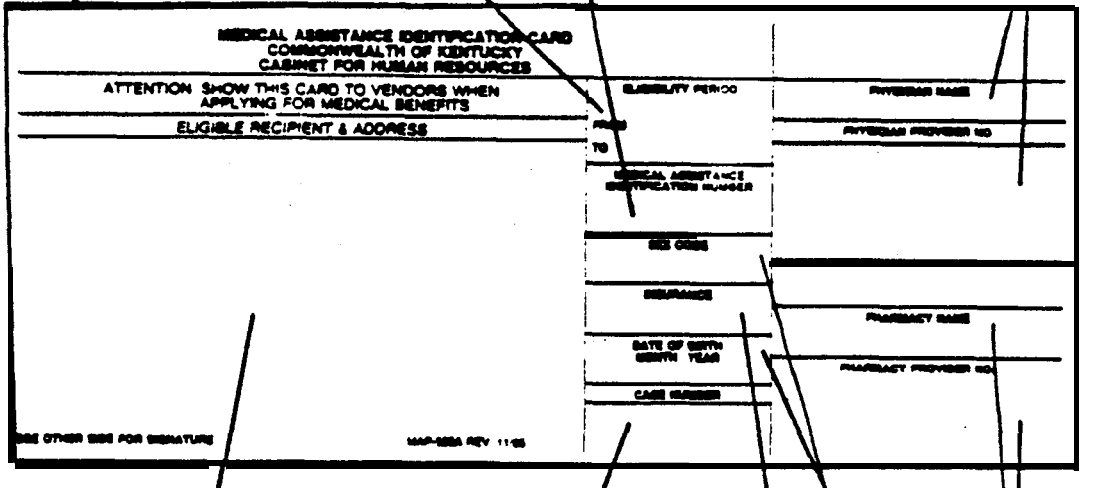
KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR LOCK-IN PROGRAM

(FRONT OF CARD)

Medical Assistance Identification Number (MAID) fs the 10-digit number required for billing medical services on the claim form.

Eligibillty Period shows dates of eligibility represented by this card "From" date is first day of eligibility of this card. "To" date is the day eligibility of this card ends and is not included as an eligible day.

Name and provider number of Lock-In physicfan. KMAP payments will be limited to this physician (with the exception of emergency services and physician referrals) unless otherwise authorized by the KMAP.



Name and address of member eligible for Medical Assistance benefits. All eligible individuals in the Lock-In Program will receive a separate card.

Insurance Code

Currently Left Blank

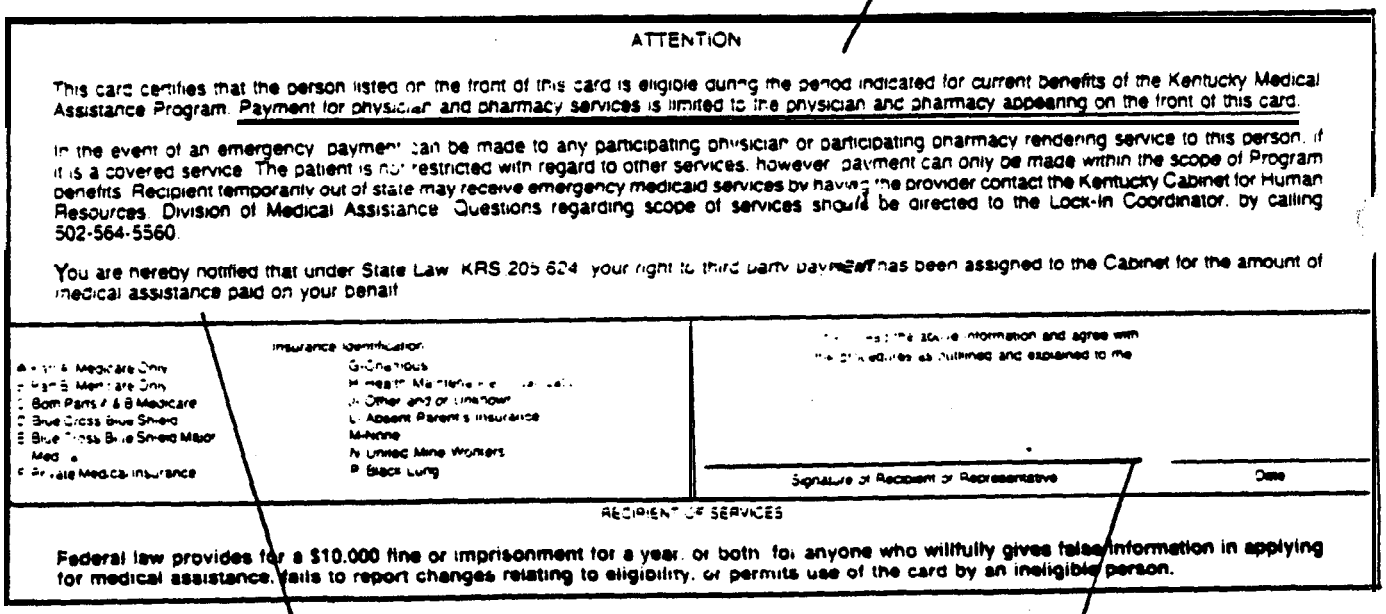
Name, address, and provider number of lock-in pharmacy. Payment for pharmacy services is limited to this pharmacy, except in cases of emergency. In case of emergency, payment for covered services can be made to any participating pharmacy, provided notification and justification of the service is given to the lock-in program.

Department for Social Insurance case number. This is NOT the Medical Assistance Identification Number.

KENTUCKY MEDICAL-ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR LOCK-IN PROGRAM

(BACK OF CARD)

Information to Providers, including procedures for emergency treatment, and identification of insurance as shown on the front of the card in "Ins." block.



ATTENTION

This card certifies that the person listed on the front of this card is eligible during the period indicated for current benefits of the Kentucky Medical Assistance Program. Payment for physician and pharmacy services is limited to the physician and pharmacy appearing on the front of this card.

In the event of an emergency payment can be made to any participating physician or participating pharmacy rendering service to this person, if it is a covered service. The patient is not restricted with regard to other services, however payment can only be made within the scope of Program benefits. Recipient temporarily out of state may receive emergency medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Division of Medical Assistance. Questions regarding scope of services should be directed to the Lock-In Coordinator, by calling 502-564-5560.

You are hereby notified that under State Law KRS 205.624 your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf

Insurance Identification:
G-Champus
M-Health Maintenance Organization
W-Other and or Unknown
L-Absent Parent's Insurance
N-None
V-Unmed Mine Workers
P-Black Lung

Signature of Recipient or Representative

Date

RECIPIENT OF SERVICES

Federal law provides for a $10,000 fine or imprisonment for a year, or both, for anyone who willfully gives false information in applying for medical assistance, fails to report changes relating to eligibility, or permits use of the card by an ineligible person.

Notification to recipient of assignment to the Cabinet for Human Resources of third party payments.

Recipient's signature is not required.

KENTUCKY PATIENT ACCESS AND CARE (KENPAC) SYSTEM CARD

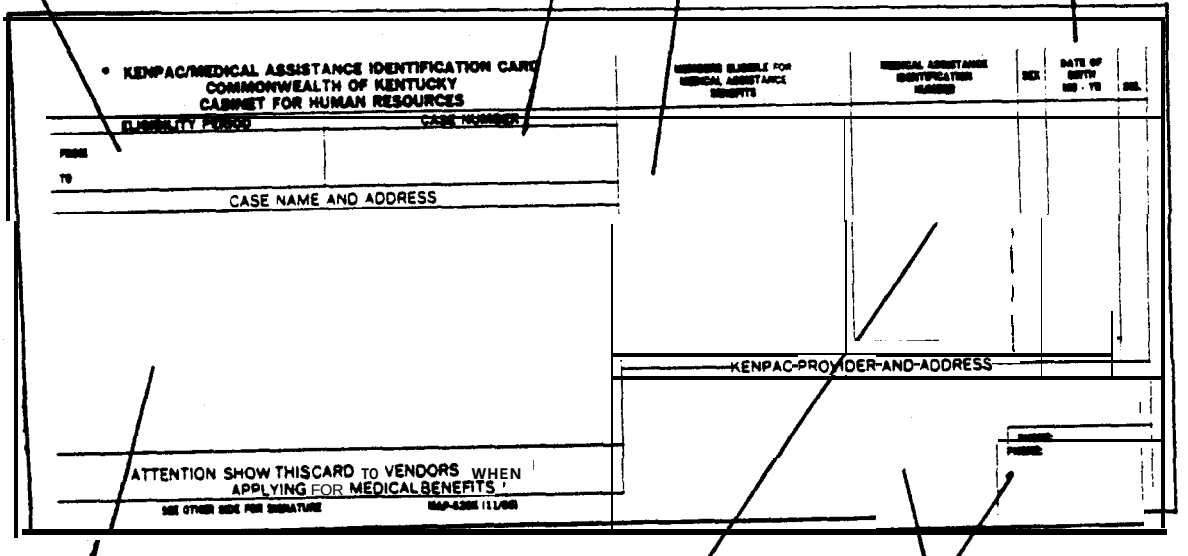
(FRONT OF CARD)

Department for Social Insurance case number. This is NOT the Medical Assistance Identification Number.

Eligibility Period shows dates of eligibility represented by this card. "From" date is first day of eligibility of this card. "To" date is the day eligibility of this card ends and is not included as an eligible day. KenPAC services provided during this eligibility period must be authorized by the Primary Care physician listed on this card.

Names of members eligible for KMAP. Persons whose names are in this block have the Primary Care provider listed on this card.

Date of Birth shows month and year of birth of each member. Refer to this block when providing services limited to age.



Case name and address show to whom the card is mailed. This person may be a relative or other interested party and may not be an eligible member.

Name, address and phone number of the Primary Care Physician.

Medical Assistance Identification Number (MAID) is the lo-digit number required for billing medical services on the claim form.

KENTUCKY PATIENT ACCESS AND CARE (KENPAC) SYSTEM CARD

(BACK OF CARD)

Information to Providers, including Insurance Identification codes which indicate type of insurance coverage as shown on the front of the card in "Ins." block.

Information to Recipients, including limitations, coverage and emergency care through the KenPAC system.

PROVIDERS OF SERVICE

This card certifies that the person listed hereon is eligible during the period indicated on the reverse side, for current benefits of the Kentucky Medical Assistance Program. The Medical Assistance Identification No. must be entered on each billing statement precisely as contained on this card in order for payment to be made.

NOTE: This person is a KenPAC recipient, and you should refer to sections (1) and (2) under "Recipient of Services."

Questions regarding provider participation, type, scope and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to:

Cabinet for Human Resources
Department for Social Insurance
Division of Medical Assistance
Frankfort, Kentucky 40621

Insurance Identification

A—Part A, Medicare Only
B—Part B, Medicare Only
C—Both Parts A & B Medicare
D—Blue Cross/Blue Shield
E—Blue Cross/Blue Shield Major Medical
F—Private Medical Insurance
G—Champus
H—Health Maintenance Organization
J—Other and/or Unknown
L—Absent Parent's Insurance
M—None
N—United Mine Workers
P—Black Lung

RECIPIENT OF SERVICES

1. The designated KenPAC primary provider must provide or authorize the following services: physici inpatient and outpatient, home health agency, laboratory, ambulatory surgical center, primary c rural health center, and nurse anesthetist. Authorization by the primary provider is not requir ices provided by ophthalmologists or board eligible or board certified psychiatrists, for obstetric provided by an obstetrician or gynecologist, or for other covered services not listed above.
2. In the event of an emergency, payment can be made to a participating medical provider render to this person, if it is a covered service, without prior authorization of the primary provider sh reverse side.
3. Covered services which may be obtained without preauthorization from the KenPAC primary clude services from pharmacies, community mental health centers, nursing homes, interm facilities, mental hospitals, nurse midwives, and participating providers of dental, hearing, vision non-emergency transportation, screening, family planning services, and birthing centers.
4. *Show this card to the person who provides these services to you whenever you receive me*
5. You will receive a new card at the first of each month as long as you are eligible for benefit protection. please sign on the line below and destroy your old card. Remember that it is agai for anyone to use this card except the person listed on the front of this card.
6. If you have questions, contact your eligibility worker at the county office.
7. Recipient(s) temporarily out of state may receive emergency Medicaid services by having the or tact the Kentucky Cabinet for Human Resources, Division of Medical Assistance.

Signature

RECIPIENT OF SERVICES: You are hereby notified that under State Law, KRS 205.624, your right to third party payment has been assigned to the Ca the amount of medical assistance paid on your behalf.

Federal law provides for a $10,000 fine or imprisonment for a year, or both, for anyone who willfully gives false information in applying for medical as fails to report changes relating to eligibility, or permits use of the card by an ineligible person.

Notification to recipient of assignment to the Cabinet for Human Resources of third party payments.

Recipient's signature is not required.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

PROVIDER AGREEMENT

Any mental hospital wishing to participate in the KMAP must submit a Provider Agreement (MAP-343). The signina of a Provider Agreement does not commit the the facility to participate but indicates the intent to participate. The Provider Agreement does not become a legal contract until the facility has been approved and the Provider Agreement has been signed by the authorized official, Department for Medicaid Services.

A. The Provider Agreement (MAP-343) is to be reviewed by the governing body, completed by the authorized representative of the facility having authority to commit the facility to the terms of the contract, and the original and yellow copy submitted to Provider Enrollment, Department for Medicaid Services. The yellow copy will be returned to the facility when certification is completed.

B. Instructions for Completing the Provider Agreement

Provider Number -- Will be completed by KMAP.

Lines 1-2 -- Enter the date on which the agreement is submitted.

Line 4 -- Enter the name of the facility as it appears on the license.

Line 5 -- Enter the address of the actual location of the facility.

Under the "WITNESSETH, THAT:" section, enter level of care in the two (2) spaces indicated.

Page three, item 5 will be completed by the KMAP after the facility has been certified.

Page three, "PROVIDER" section must be signed and completed by the authorized representative of the facility.

PROVIDER AGREEMENT (MAP-3431

MAP-343 (Rev. 5/86)

Provider Number: _____
(If Known)

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES
PROVIDER AGREEMENT

THIS PROVIOER AGREEMENT, made and entered into as of the ___ day of _____, 19__, by and between the Commonwealth of Kentucky, Cabinet for Human Resources, Oepartment for Medicaid Services, hereinafter referred to as the Cabinet, and _____
(Name of Provrder)

_____
(Address of Provider)

hereinafter referred to as the Provider.

WITNESSETH, THAT:

Whereas, the Cabinet for Human Resources. Department for Medicaid Services, in the exercise of its lawful duties in relation to the administration of the Kentucky Medical Assistance Program (Title XIX) is required by applicable federal and state regulations and policies to enter into Provider Agreements; and

Whereas, the above named Provider desires to participate in the Kentucky Medical Assistance Program as a

_____
(Type of Provider and/or level of care)

Now, therefore, it is hereby and herewith mutually agreed by and between the parties hereto as follows:

1. The Provfder:

(1) Agrees to comply with and abfde by all applicable federal and state laws and regulations, and with the Kentucky Medical Assistance Program policies and procedures governinq Title XIX Providers and recipients.

(2) Certifies that he (it) is licensed as a _____, if applicable, under the laws of Kentucky for the level or type of care to which this agreement applies.

(3) Agrees to comply with the civil rights requirements set forth in 45 CFR Parts 80, 84, and 90. (The Cabinet for Human Resources shall make no payment to Providers of service who discriminate on the basis of race, color. national origin, sex, handicap, religion, or age in the provision of services.)

PROVIDER AGREEMENT (MAP-343)

HAP-343 (Rev. 5/86)

(4) Agrees to maintain such records as are necessary to disclose the *extent* of services furnished to Title XIX recipients for a minimum of 5 years and for such additional time as may be necessary in the event *of* an audft exception or other dispute and to furnish the Cabinet with any information requested regarding payments claimed for furnishing services.

(5) Agrees to permit representatives of the state and/or federal government to have the right to examine, inspect, copy and/or audit all records pertaining to the provision of services furnished to Title XIX recipients. (Such examinations, inspections, copying and/or audits may be made without prior notice to the Provider.)

(6) Assures that he (it) is aware of Section 1909 of the Social Security Act; Public Law 92-603 (As Amended), reproduced on the reverse side of this Agreement and of KRS 194.500 to 194.990 and KRS 205.845 to 205.855 and 205.990 relating to medical assistance fraud.

(7) Agrees to inform the Cabinet for Human Resources, Department for Medicaid Services, within 30 days of any change in the following:

(a) name;
(b) ownership;
(c) licensure/certification/regulation status; or
(d) address.

(8) Agrees not to discriminate in services rendered to eligible Title XIX recipients on the basis of marital status.

(9) (a) In the went that the Provider is a soecfalty hospital providing services to persons aged 65 and over, home health agency, or a skilled nursing facility, the Provider shall be certified for participation under Title XVIII of the Social Security Act.

(b) In the event that the Provider is a specialty hospital providing psychiatric services to persons age 21 and under, the Provider shall be approved by the Joint Commission on Accreditation of Hosoitals. In the event that the Provider is a general hospital, the Provider snail be certified for participation under Title XVIII of the Social Security Act or the Joint Commission on Accreditation of Hospitals.

(IO) In the event that the provider desires to participate in the physician or dental clinic/corporation reimbursement system, Kentucky Medical Assistance Program payment for physicfans' or dentists' services orovided to recipients Of the Kentucky Medical Assistance Program will be made directly to the clinic/corporation upon proper issuance by the employed physician or dentist of a Statement of 4uthorftation (MAP-347).

This clinic/corporation does meet the definition established for participation and does hereby agree to abide by all rules, regulations, Policies and procedures pertaining to the clinic/corporation reimbursement system.

2. In consideration of approved services rendered to Title XIX recipients certified by the Kentucky Medical Assistance Program, the Cabinet for Human Resources, Department for Medicaid Services agrees, subject to the availability of federal and state funds, to reimburse the Provider in accordance with current applicable federal and state laws. rules and regulations and policies of the Cabinet for Human Resources. Payment shall be made only upon receipt of appropriate billings and reports as prescribed by the Cabinet for Human Resources, Department for Medicaid Services.

PROVIDER AGREEMENT (MAP-343)

PAP-343 (Rev. 5/80)

3. Either party shall have the right to teninate this agreement at any time upon 30 days' written *notice* served upon the ocher party by certified or registered mail; provided. however, that the Cabinet for Human Resources, Department for *Medicaid Services, may* terminate this agreement immediately *for* cause, or in accordance with federal regulations, upon written notice served upon the Provider by registered or Certified mail with return receipt requested.

4. In the event of a change of ownership of an SNF, ICF, or ICF/MR/DD facility, the Cabinet for Human Resources agrees to autcmatically assign this agreement to *the new owner* in accordance with 42 CFR 442. lb.

5. In the event the named Provider *in this agreement is an* SNF, ICF, or ICF/MR/DD *this* agreement shall begin on _____,19___, with conditional termination on _____, 19___, and shall automatically terminate on _____, 19___, unless the facility is recertified in accordance with applicable regulations and policies.

PROVIDER	CABINET FOR HUMAN RESOURCES DEPARTMENT FOR MEDICAID SERVICES
BY: _____ Signature of Authorized Official	BY: _____ Signature of Authorized Official
NAME: _____	NAME: _____
TITLE: _____	TITLE: _____
OATE: _____	DATE: _____

-3-

PROVIDER AGREEMENT (MAP-343)

P.L. 92-603 LAWS OF 92nd CONG.--2nd SESS. (As Amended)

PENALTIES

Section 1909. (a) Whoever--

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than 125.000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under this title is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind--

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25.000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person--

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to--

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(d) Whoever knowingly and willfully--

(1) charges, for any service provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates established by the State, or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient,--

(A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or

(B) as a requirement for the patient's continued stay in such a facility,

when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

PROVIDER INFORMATION

Each mental hospital must complete a Provider Information form (MAP-344) and submit it as requested. Any changes in submitted information are to be reported in writing to Provider Enrollment, Department for Medicaid Services as the changes occur.

Instructions for Completing the Provider Information Form (MAP-344)

1. Enter the name of the facility as shown on the facility license.
2-3. Enter mailing address.
4. Enter telephone number, including area code.
5. Enter the name of the person, agency or corporation to whom payment is to be made.
6. If address of payee is different from facility as listed on lines 2-3, enter the address of payee.
7. Enter Federal Employer ID number.
8. Not applicable.
9. Enter number as shown on facility license.
10. Enter name of the facility licensing board.
11. Enter original facility license date of the present owner.
12. Enter provider number assigned by KMAP, if known.
13. Enter mental hospital Medicare provider number if known.
14. Check the applicable types of practice organization. Two types should be checked. If incorporated, check either Corporation (Public) or Corporation (Private); if not incorporated check either Individual Practice or Partnership. Profit or Non-Profit must be checked.

    a. Corporation (Public) - an incorporated public facility such as one owned and operated by a municipal district.
    b. Corporation (Private) - an incorporated private facility.
    c. Health Maintenance Organization - not applicable to hospitals.
    d. Individual Practice - a facility owned by a single individual.
    e. Partnership - a facility owned by two or more persons.
    f. Profit - a facility operated on a profit making basis.
    g. Hospital-Based Physician - Physicians employed by/under contract to the hospital and not billing third parties for their services.
    h. Group Practice - not applicable to hospitals.
    i. Non-Profit - a facility not operated on a profit making basis.

PROVIDER INFORMATION

15. Not applicable.

16. Enter name of corporation owning the facility, address and telephone number of Home Office. Give names and addresses of corporation officers (attach a continuation sheet if necessary).

17. Enter names and addresses of partners in a partnership (attach a continuation sheet if necessary).

18-22. Not applicable.

23. Check only one block under this section.

24. Enter the fiscal year ending date as established by the facility.

25-29. Self-explanatory.

30. Complete only if applicable, add continuation sheet if additional space is necessary.

31. Enter the name and home office address of the firm managing the facility if different from ownership.

32. Enter the name and address of the owner of the facility if leased to the party indicated on line number one.

33. Enter the number of licensed beds, as shown on license for their corresponding level of care, and total beds certified under each level of care as Title XIX.

34. %&explanatory. If additional space is needed, use a continuation

35-36. Not applicable.

37. Enter signature of person authorized by facility to submit information. Type or print name of authorized person below the signature with his/her title. Date the information sheet on the date of completion.

PROVIDER INFORMATION (MAP-344)

MAP-3U (Rev. 08/85)

KENTUCKY MEDICAL ASSISTANCE **PROGRAM**

Provfder **Information**

1. **Name:** _____

2. _____
Street Address, P.O. Box. Route Number (In Care of. Attention, etc.)

3. _____ _____ _____
City State tip Code

4. _____
Area Coae Telephone Number

5. _____
Pay to, In Care of, Attention, etc. (If different **from** above)

6. _____
Pay to Address (If different fran above)

7. Federal Employer ID Number: _____

a. Social Security Number: _____

9. License Number: _____

10. **Licensing Board** (If **Applicable**): _____

11. Original **License** Date: _____

12. **KMAP** Provider Number (If Known): _____

13. Medicare Provider Number (If Applicable): _____

14. Provider **Type** of Practice Organization:

/_/ Corporation (Public) /_/ Individual Practice /_/ Hospital-Based Physician
/_/ Corporation (Private) /_/ Partnership /_/ Group **Practice**
/_/ Health Maintenance Organization /_/ Profit /_/ Non-Profit

15. If group practice. Number of Providers in Group (specify provider type):

_____

-1-

PROVIDER INFORMATION (MAP-344)

RAP-344 (Rev, 08/85)

16. If corporation. name, address and telephone number of Home Office:

Name: _____

Address: _____

_____

Telephone Number: _____

Name and Address of Officers:

_____

_____

_____

_____

_____

17. If Partnership, name and address of Partners:

_____

_____

_____

_____

_____

18. National Pharmacy Number (If Applicable): _____
(Seven-Digit Number Assigned by National Pharmaceutical Association)

19. Physician/Professional Specialty:

_____

2nd _____

3rd _____

20. Physician/Professional Specialty Certification:

1st _____

2nd _____

3rd _____

-2-

PROVIDER INFORMATION (MAP-344)

HAP-344 (Rev. 08/85)

21. Physician/Professional Specialty Certification Board:

1st _____ Date: _____

2nd _____ Date: _____

3rd _____ Date: _____

22. Name of Clinic(s) in Which Provide. is a Member:

_____

2nd _____

3rd _____

4th _____

23. Control of Medical Facility:

/_/ Federal /_/ State /_/ County /_/ City /_/ Charitable or Religious

/_/ Proprietary (Privately owned) /_/ Other _____

24. Fiscal Year End: _____

25. Administrator: _____ Telephone No. _____

26. Assistant Administrator: _____ Telephone No. _____

27. Controller: _____ Telephone No. _____

28. Independent Accountant or CPA: _____ Telephone No. _____

29. If sole proprietorship, name, address, and *telephone* number of owner:

Name: _____

Address: _____

Telephone No. _____

30. If facility is government owned, list names and addresses of board members:

	Name	Address
President or Chairman of Board:		
Member:		
Member:		
Member:		
Member:		

-3-

PROVIDER INFORMATION (MAP-344)

MAP-344 (Rev. 08/85)

31. Management Firm (If Applicable):

Name : _____

Address: _____

32. Lessor (If Applicable):

Name: _____

Address: _____

33. Distribution of Beds in Facility (Canplete for all levels of care):

	Total Licensed Beds	Total Title XIX Certified Beds
Hospital Acute Care		
Hospital Psychiatric		
Hospftal TB/Upper Respiratory Disease		
Skflled Nursing Facflfty		
Intermediate Care Facility		
ICF/MR/DD		
Personal Care Facility		

34. SNF, ICF, ICF/MR/DD Owners with 5% or More Ownersnip:

Name	Address	Percent of Ownership

PROVIDER INFORMATION (MAP-344)

W-344 (Rev. 08/85)

35. Institutional Review Committee Members (If Applicable):

36. Providers of Transportation Services:

No. of Ambulances in Operation:_____ No. of Heelchair Vans in Operation:_

Total No. of Employees:_____ (Enclose list Of names, ages, experience & Training.)

Current Rates:

A. Basic Rate $_____ (Includes up to _____ miles.)

B. Per Mile $_____

C. Oxygen $_____ E. Other

D. Extra Patient $_____ _____ $_____

37. Provider Authorized Signature: I certify, under penalty of law. that the information given in this Information Sheet is correct and complete to the best of my knowledge. I am aware that, should investigatfon at any time show any falsification, I will be considered for suspension from the Program and/or prosecution for Medicaid Fraud. I hereby authorize the Cabinet for Human Resources to make all necessary verifications concerning me and my medical practice, and further authorize and request each educational institute, medical/license board or organization to provide all information that may be sought in connection with my application for Participation in the Kentucky Medical Assistance Program.

Signature: _____

Name: _____

Title: _____ Date: _____

INTER-OFFICE USE ONLY

License Number Verified through_____(Enter Code)

Comments: _____

Date: _____ Staff: _____

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

MEMORANDUM TO LOCAL D.S.I. OFFICE (MAP-24)

The MAP-24 is used to report the discharge or death of any Title XIX recipient to the local Department for Social Insurance office. This flow of information is essential to timely payment to the facility and efficient records for the Department for Social Insurance.

Complete all entries as appropriate and mail to the local Department for Social Insurance office within ten days of recipient discharge or death.

MEMORANDUM TO LOCAL D.S.I. OFFICE (MAP-24)

CABINET FOR HUMAN RESOURCES
COMMONWEALTH OF KENTUCKY
FRANKFORT 40621-0001

DEPARTMENT FOR MEDICAID SERVICES
An Equal Opportunity Employer M F H

_____ (Date)

M E M O R A N D U M

TO: Local Office
Department for Social Insurance

FROM: _____ (Facility/Waiver Agency)

SUBJECT: _____ (Recipient Name) (Social Security/Medicaid No.)

_____ (Previous Address)

_____ (Responsible Relative's Name and Address

This is to notify you that the above-referenced recipient

☐ was admitted to this facility/waiver agency _____ (Date)

is in Title _____ (XVIII or XIX) Payment Status, and was placed in an

☐ SNF bed ☐ ICF bed ☐ ICF/MR/DD bed ☐ MI bed

☐ HCBS Waiver Service ☐ AIS/MR Waiver Service, and/or

☐ was discharged from this facility/waiver agency on _____ (Date)

and went to _____ (Home Address/Name & Address of New Facility/Waiver Agency) and/or

☐ expired on _____ (Date).

_____ (Signature)

MAP-24
(Rev. 03/88)

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

STATEMENT OF AUTHORIZATION (MAP-347)

PAP-347
(02/86)

KENTUCKY MEDICAL ASSISTANCE PROGRAM
STATEMENT OF AUTHORIZATION

I hereby declare that I, _____
(Licensed Professional)

a duly-licensed _____, have entered into a

contractual agreement with _____
(Clinic/Corporation or Facility Name)

_____
(City. State, & Zip Code)

to provide professional services. I authorize payment to

_____
(Clinic/Corporation or Facility Name)

fraa the Kentucky Medical Assistance Program for covered services provided by me and specified by the criteria of our contract. I undentand that I. personally, cannot bfll the Kentucky Medical Assistance Program for any service that is reimbursed to _____
(Clinic/Corporation or Facility Name)

as part of our contractual agreement, and that I am solely and completely responsible for all Kentucky Medical Assistance Program documents submitted by this employer in my name for services I provided.

_____ _____
Signature of Professional 'bate Signed

_____ _____
License and/or Certification Number Specialty

_____
Social Security Number

_____
Federal Employer Identification Number

_____
KMAP Provider Number of
Clinic/Corporation or Facility

STATEMENT OF AUTHORIZATION (MAP-347)

P.L. 92-603 LAWS OF 92nd CONG.--2nd SESS. (As Amended)

PENALTIES

Section 1909. (a) Whoever--

(1) knowingly and willfully makes or causes CO be made any false statement or representation of , material fact in any application for any benefit or payment under a State plan approved under this title,

(2) at any time knowingly and willfully makes or causes to be made my false statement or representation of , material fact for use In determining rights to such benefit or payment,

(3) having knowledge Of the occurrence of any event affecting (A) his initial or continued right to any such benefit Or payment, Or (B) the initial or continued right to any Such benefit or payment Of any other individual in whose behalf he has applied for or Is receiving such benefit or payment, conceals Or fails to disclose such event with an intent fraudulently to secure such benefit or payment either In , greater amount or quantitythan is due or when no such benefit or payment is authorized, or

(4) having madeapplication to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person.

shall (1) in the case of such , statement, representation, concealment, failure, or conversion by any person in connection with th. furnishing (by that person) of items or services for which payment IS or may be ""4. under this title, be guilty of, felony and upon conviction thereof fined not more than $25,000 or imprisoned for not mom than five years Or both, or (11) in the case of such , statement, representation, concealment, failure, or conversion by my other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under this title Is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any Other provision of this title or of such plan) limit, restrict, or suspend the eligibility Of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition Of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless Of the relationship between that individual and such other person.

(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash Or in kind--,

(A) in return for referringan individual to , person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) In return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly Or indirectly, overtly or covertly, in cash or in kind to my person to induce such person--

(A) to refer an individual to a personfor the furnishing or arranging for the furnishing of any item or service for which payment may be made In whole or In part under this title, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, OI ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty Of, felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to--a

(A) , discount or other reduction in price obtained by, provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and

(B) any amount paid by an employer to an employee (who has , bon, fide employment relationship with such employer) for employment in the provision of covered items or services.

(c) Whoever knalnqly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of, material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as , hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of , felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or bath.

(d) Whoever knalnqly and willfully--

(1) charges, for any service provided to a patient under , State plan approved under this title, money or other consideration at , rate in excess Of the rates established by theState,or

(2) charges, solicits, accepts, or receives, In addition to any amount otherwise required to be paid under , State plan approved under this title, any gift, money, donation, or other consideration (other than , charitable, religious, or philanthropic contribution from an organization or from , person unrelated to the patient)--

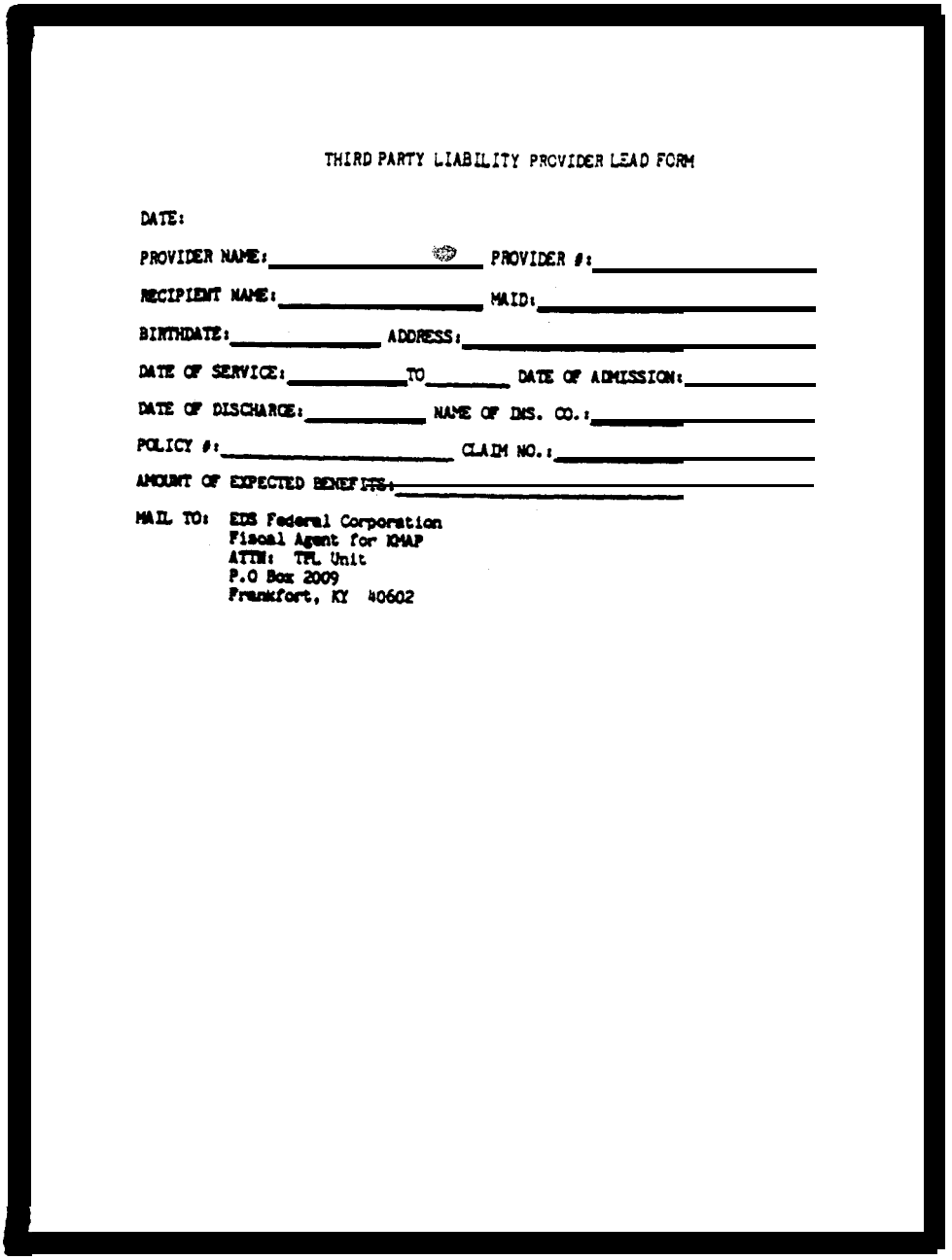
(A) as , precondition Of admitting a patient CO , hospital, skilled nursing facility, or intermediate care facility, or

(B) as requirement for the patient's continued stay in such , facility,

when the cost Of tne services provided therein to the patient is paid for (in whole or in part) under the State plan,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

THIRD PARTY LIABILITY PROVIDER LEAD FORM



THIRD PARTY LIABILITY PROVIDER LEAD FORM

DATE:

PROVIDER NAME:_____ PROVIDER #:_____

RECIPIENT NAME:_____ MAID:_____

BIRTHDATE:_____ ADDRESS:_____

DATE OF SERVICE:_____TO_____ DATE OF ADMISSION:_____

DATE OF DISCHARGE:_____ NAME OF INS. CO.:_____

POLICY #:_____ CLAIM NO.:_____

AMOUNT OF EXPECTED BENEFITS:_____

MAIL TO: EDS Federal Corporation
Fiscal Agent for KMAP
ATTN: TPL Unit
P.O Box 2009
Frankfort, KY 40602

MAP-346

MAP-346
(8/82)

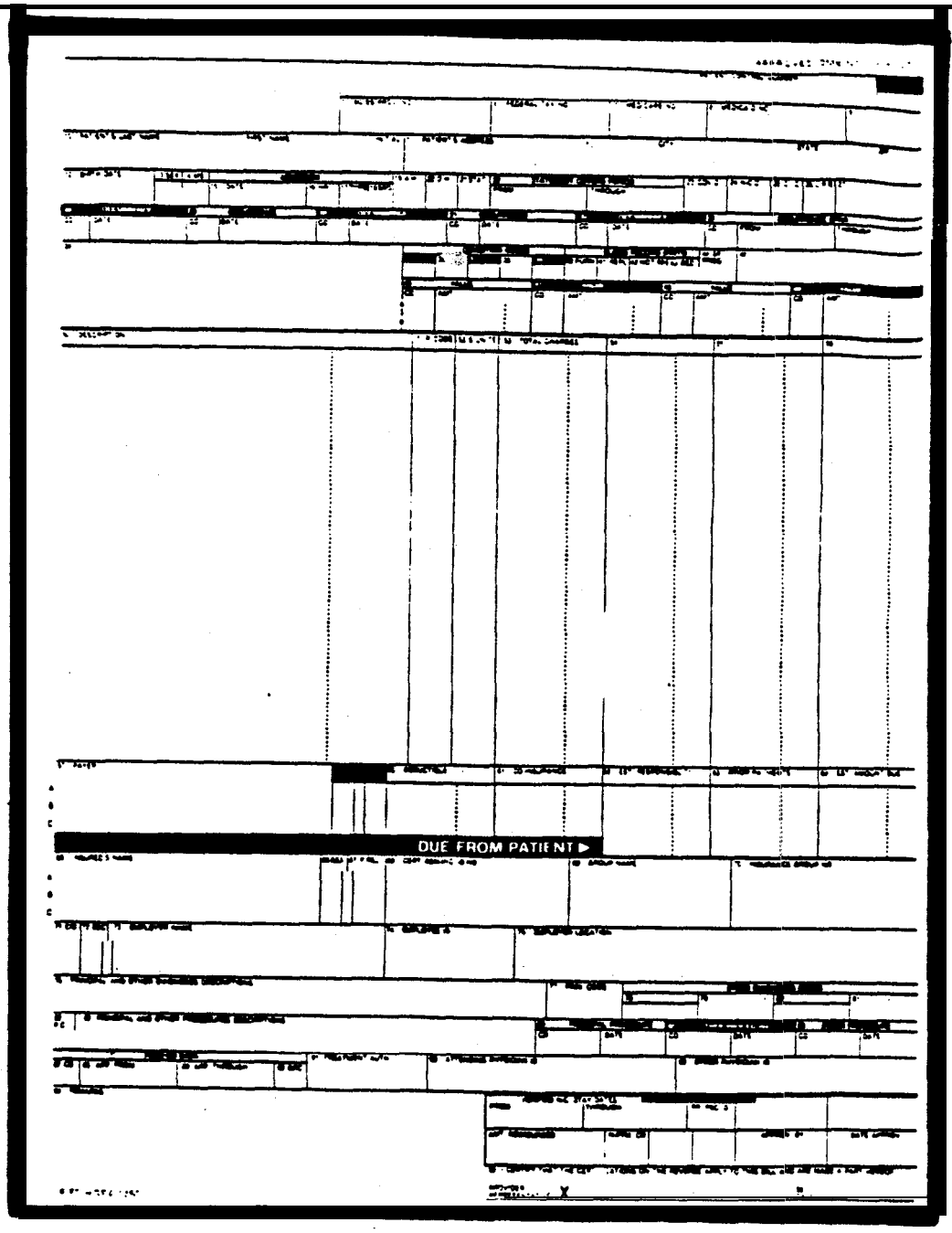
KENTUCKY MEDICAL ASSISTANCE PROGRAM
CERTIFICATION OF CONDITIONS MET
FACILITY-BASED MEDICAL PROFESSIONALS REMUNERATION
AS AN ELEMENT OF FACILITY'S REIMBURSABLE COST

This is to certify that each of the following named licensed medical professionals is currently entered into financial arrangements with _____ (Facility Name) _____ (City) _____ (State), for the purpose of rendering his/her special services to patients of this facility, and that currently on file in this care center is a Statement of Authorization executed by each of these individuals which authorizes payment by the KMAP to the _____ (Facility Name) for services rendered eligible Program beneficiaries.

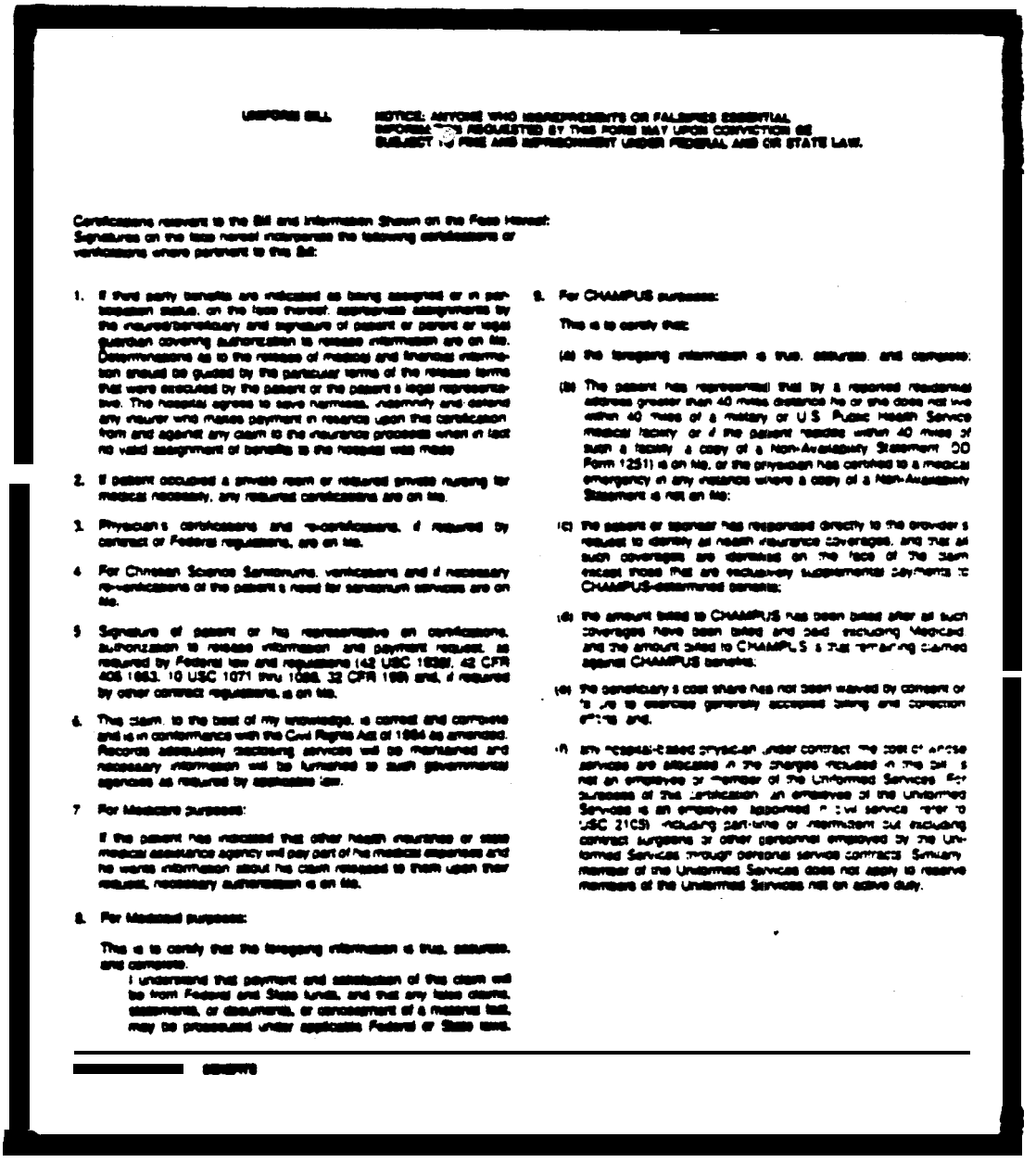
NAME	LICENSE NUMBER	POSITION (Physician, Psychiatrist, etc.)	OATE OF CENTER EMPLOYMENT

Signed _____
Facility Administrator

UNIFORM BILLING FORM (UB-82 HCFA-1450)



UNIFORM BILLING FORM (UB-82 HCFA-1450)



UNIFORM BILL NOTICE: ANYONE WHO MISREPRESENTS OR FALSIFIES ESSENTIAL INFORMATION REQUESTED BY THIS FORM MAY UPON CONVICTION BE SUBJECT TO FINE AND IMPRISONMENT UNDER FEDERAL AND OR STATE LAW.

Certifications relevant to the Bill and Information Shown on the Face Hereof: Signatures on the face hereof incorporate the following certifications or verifications where pertinent to this Bill:

1. If third party benefits are indicated as being assigned or in possession status, on the face hereof, appropriate assignments by the insured/beneficiary and signature of patient or parent or legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the particular terms of the release forms that were executed by the patient or the patient's legal representative. The hospital agrees to save harmless, indemnify and defend any insurer who makes payment in reliance upon the certifications from and against any claim to the insurance proceeds which in fact no valid assignment of benefits to the hospital was made.

2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.

3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.

4. For Christian Science Sanatorium, verifications and if necessary re-verifications of the patient's need for sanatorium services are on file.

5. Signature of patient or his representative on certifications, authorization to release information and payment request, as required by Federal law and regulations (42 USC 1935f, 42 CFR 405.1663, 10 USC 1071 thru 1086, 32 CFR 199 and, if required by other contract regulations, is on file.

6. This claim, to the best of my knowledge, is correct and complete and is in conformance with the Civil Rights Act of 1964 as amended. Records adequately disclosing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.

7. For Medicare purposes:

If the patient has indicated that other health insurance or state medical assistance agency will pay part of his medical expenses and he wants information about his claim released to them upon their request, necessary authorization is on file.

8. For Medicaid purposes:

This is to certify that the foregoing information is true, accurate, and complete.

I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

9. For CHAMPUS purposes:

This is to certify that:

(a) the foregoing information is true, accurate, and complete;

(b) The patient has represented that by a reported residential address greater than 40 miles distance he or she does not live within 40 miles of a military or U.S. Public Health Service medical facility or if the patient resides within 40 miles of such a facility a copy of a Non-Availability Statement DD Form 1251 is on file, or the physician has certified to a medical emergency or any instance where a copy of a Non-Availability Statement is not on file;

(c) the patient or sponsor has responded directly to the provider's request to identify all health insurance coverages, and that all such coverages are identified on the face of the claim except those that are exclusively supplemental payments to CHAMPUS-determined benefits;

(d) the amount billed to CHAMPUS has been billed after all such coverages have been billed and paid (excluding Medicaid) and the amount billed to CHAMPUS is that remaining claimed against CHAMPUS benefits;

(e) the beneficiary's cost share has not been waived by contract or failure to exercise generally accepted billing and collection efforts; and,

(f) any hospital-based physician under contract, the costs of whose services are included in the charges included in this bill, is not an employee or member of the Uniformed Services for purposes of this certification. An employee of the Uniformed Services is an employee appointed, civil service (refer to USC 2105) including part-time or intermittent but excluding contract surgeons or other personnel employed by the Uniformed Services through personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.

SIGNATURE

PROVIDER AGREEMENT ADDENDUM (MAP-380)

(MAP-380, 11/86)

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES
KENTUCKY MEDICAL ASSISTANCE PROGRAM

PROVIDER AGREEMENT ADDENDUM

This addendum to the Provider Agreement, is made and entered into as of the _____ day _____ of _____, 19___, by and between the Commonwealth of Kentucky, Cabinet for Human Resources, Department for Medicaid Services, hereinafter referred to as the Cabinet, and _____

_____,
Name and Address of Provider
hereinafter referred to as the Provider.

WITNESSETH, THAT:

Whereas, the Cabinet for Human Resources, Department for Medicaid Services, In the exercise of Its lawful duties In relation to the administration of the Kentucky Medical Assistance Program (Title XIX) ts required by applicable federal and state regulations and polices to enter into Provider Agreements; and

Whereas, th above named Provider participates In the Kentucky Medical Assistance Program as a

_____
(Type of Provider and/or level of care) (Provider Number)

Now, therefore, it is hereby and herewith mutually agreed by and between the parties hereto as follows:

1. The Provider:

(A) Desires to submit claims for services provided to recipients of the Kentucky Medical Assistance Program (Title XIX) via electronic media rather than via paper forms prescribed by the KMAP.

(B) Agrees to assume responsibility for all electronic media claims, whether submitted directly or by an agent.

(C) Acknowledges that the Provider's signature on this Agreement Addendum constitutes compliance with the following certification required of each individual claim transmittal by electronic media:

"This is to certify that the transmitted information is true, accurate, and complete and that any subsequent transactions which alter the information contained therein will be reported to the KMAP. I understand that payment and satisfaction of these claims will be from Federal and State funds and that my false claims, statements, or documents or concealment of a material fact, my be prosecuted under applicable Federal and State Law."

PROVIDER AGREEMENT ADDENDUM (MAP-380)

(D) Agrees to use EMC submittal procedures and record layouts as defined by the Cabinet.

(E) Agrees to refund any payments which result from claims being paid inappropriately or inaccurately.

(F) Acknowledges that upon acceptance of this Agreement Addendum by the Cabinet, said addendum becomes part of the previously executed Provider Agreement. All provisions of the Provider Agreement remain In force.

2. The Cabinet:

(A) Agrees to accept electronic media claims for the services performed by this provider and to reimburse the provider in accordance with established policies.

(B) Agrees to assign to the provider or its agent a code to enable the media to be processed.

Either party shall have the right to terminate this Addendum upon written notice without cause.

Provider

BY: _____
Signature Of Provider

Name: _____

Title: _____

Date: _____

Cabinet for Human Resources
Department for Medicaid Services

BY: _____
Signature of Authorized Official or Designee

Name: _____

Title: _____

Date: _____

NOTICE OF AVAILABILITY OF INCOME FOR LONG TERM CARE/WAIVER AGENCY/HOSPICE (MAP-552)

MAP-552
(R. 4/88)

COMMONWEALTH OF KENTUCKY
Cabinet for Human Resources
Department for Social Insurance

NOTICE OF AVAILABILITY OF INCOME
FOR LONG TERM CARE/WAIVER
AGENCY/HOSPICE

A. Case Name _____
[ ] Committee [ ] Payee
Case No. _____

B. [ ]Initial [ ]Change

C. Client's Name _____ Birth Date _____ (No./Yr.) [ ]Title XVIII [ ]Title XIX

D. Current Facility/
Waiver Agency/Hospice _____ Address _____

Actual Admission Date to this Facility/Waiver Agency/Hospice _____
Date of Discharge or Date of Death (If Applicable) _____
[ ]SNF [ ]ICF [ ]ICF/MR
[ ]MR/PSY [ ]HCBS
[ ] AIS/MR [ ]Hospice

E. Previous Facility/
Waiver Agency/Hospice _____ Address _____

Admission Date _____ Date of Discharge _____ Type: [ ]SNF [ ]ICF [ ]ICF/MR [ ]MR/PSY [ ]PCH [ ]PCH [ ]HCBS [ ]AIS/MR [ ]Hospice

F. Family Status

1. [ ]Single [ ]Married No. of Children _____
Total Dependents _____

2. Spouse
[ ]Ineligible [ ]Eligible [ ]Patient [ ]Non-Patient
(Co.) (Prg.) (Number)

G. Income Computation

1. Unearned Income

Source of Unearned Income	Amount
a. RSDI (Including SMI if deduct. by SSA)	
b. SSI	
c. RR (Including SMI, if deduct. by RR)	
d. VA	
e. State Supplementation	
f. Other (Specify) _____	
g. Sub-Total Unearned Inc. (1a thru 1f)	$

2. Earned Income

	Amount
a. Income _____ (Source)	
b. Earned Income Deduction(s)	-
c. Sub-Total Earned (2a-2b)	$

3. Total Income (1g plus 2c) $

4. Deductions

	Amount
a. Incurred Medical Expenses (Exclude Health Ins. of Client)	
b. Health Insurance 1) SMI (JEN Only)	
2) Other Health Ins.	
c. Spouse/Family Maintenance	
d. Personal Needs Allowance	$
e. Total Deductions (4a thru 4d)	$

5. Available Income (3 minus 4e) $

6. Available Income (rounded) $

H. Explain Incurred Medical Expenses

List full names and policy numbers of all health insurance policies.

I. Status

1. Active Case [ ]Yes [ ]No
2. If active, Eff. Date for MA _____
3. If discontinued, Eff. Date of MA Disc. ____
4. Program Code Change [ ]Yes [ ]No
From _____ To _____ Eff. _____
5. SSI Entitlement Confirmed
Confirmation Date _____
6. Available Monthly Income (Item G-6) _____
Effective Date (Change forms only) _____

J. Comment Section

1. [ ]LOI [ ]MAP-24 [ ]MAP-37A
[ ]DMS Letter of Approval
[ ]DMR-001. . . . . (Date Received)

2. Corrected MAP-552
Correction of MAP-552 dated _____

3. [ ]Private Pay Patient
From _____ to _____

4. [ ]PAFS-105. . . Date Sent _____

5. Additional comments:

K. _____
(Signature) (Date)

AGREEMENT BETWEEN KMAP AND ELECTRONIC MEDIA BILLING AGENCY (MAP-246)

(MAP-246, Rev. 10-86)

Agreement Between the
Kentucky Medical Assistance Program
and
Electronic Media Billing Agency

This agreement regards the submission of claims via electronic media to the Kentucky Medical Assistance Program.

The _____ (Name of Billing Agency) has entered into a contract with _____ (Name of Provider), _____ (Provider Number) to submit claims via electronic media for services provided to KMAP recipients. The billing agency agrees:

1. To safeguard information about Program recipients as required by state and federal laws and regulations;

2. To maintain a record of all claims submitted for payment for a period of at least five (5) years;

3. to submit claim information as directed by the provider, understanding the submission of • electronic media claim is a claim for Medicaid payment and that my person who, with Intent to defraud or deceive, makes, or causes to be made or assists In the preparation of any false statement, misrepresentation or omission of a material fact In any claim or application for any payment, regardless of amount, knowing the same to be false, is subject to civil and/or criminal sanctions under applicable state and federal statutes.

4. To maintain on file an authorized signature from the provider, authorizing all billings submitted to the KMAP or Its agents.

The Department for Medicaid Services agrees:

1. To assign a code to the billing agency to enable the media to be processed;

2. To reimburse the provider In accordance with established policies.

This agreement may be terminated upon written notice by either party without cause.

_____
Signature, Authorized Agent of Billing Agency

_____
Date

_____
Signature, Representative of the
Department for Medicaid Services

_____
Date

REMITTANCE STATEMENT

TRANSMITTAL #9

AS OF 01/06/84 KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT Page 1

RA NUMBER
RS SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: MENTAL HOSPITAL

* PAID CLAIMS *

INVOICE NUMBER	-RECIPIENT NAME	IDENTIFICATION- NUMBER	INTERNAL CONTROL NO.	DATES OF SERVICE	TOTAL CHARGES	PROF COMP	AMT. FROM OTHER SOURCES	CLAIM PMT AMOUNT	EOB
426310	SWAVERLY	L 908324831 4	9883324-315-090	06/27/83-06/30/83	600.00	25.00	0.00	575.00	365
01 ACCOM/ANCIL B		QTY 3		06/27/83-06/30/83	575.00	0.00	0.00	550.00	365
02 ACCOM/ANCIL X		QTY 1		06/27/83-06/30/83	25.00	25.00	0.00	25.00	061

CLAIMS PAID IN THIS CATEGORY: 1 TOTAL BILLED: 600.00 TOTAL PAID: 575.00

REMITTANCE STATEMENT

TRANSMITTAL #9

AS OF 01/06/84 KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT Page 2

RA NUMBER
RS SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: MENTAL HOSPITAL

* DENIED CLAIM *

INVOICE NUMBER	-RECIPIENT NAME	IDENTIFICATION- NUMBER	INTERNAL CONTROL NO.	DATES OF SERVICE	TOTAL CHARGES	EOB
324701	STERN J	3241103240	9883250-451-060	12/20/83-12/20/83	336.00	254
01 ACCOM/ANCIL C		QTY 2		12/20/83-12/20/83	336.00	254

CLAIMS REJECTED IN THIS CATEGORY: 1 TOTAL BILLED: 336.00

REMITTANCE STATEMENT

AS OF 01/06/84 KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT Page 3

RA NUMBER
RS SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: MENTAL HOSPITAL

* CLAIMS IN PROCESS *

INVOICE NUMBER	-RECIPIENT IDENTIFICATION- NAME	NUMBER	INTERNAL CONTROL NO.	DATES OF SERVICE	TOTAL CHARGES	EOB
8362730	EDEN S	4838011143	9883324-451-037	09/02/82	400.00	260
431785	BOYD J	3232168973	9883324-451-050	09/02/83	600.00	260

CLAIMS PENDING IN THIS CATEGORY: 2 TOTAL BILLED: 1000.00

REMITTANCE STATEMENT

TRANSMITTAL #9

AS OF 01/06/84 KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT Page 4

RA NUMBER
RS SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: MENTAL HOSPITAL

* RETURNED CLAIMS *

INVOICE NUMBER	-RECIPIENT NANE	IDENTIFICATION- NUMBER	INTERNAL CONTROL NO.	CLAIM SVC. DATE	EOB
426310	SALEM J	3241060348	9883324-451-000	100483	999

TOTAL CLAIMS RETURNED IN THIS CATEGORY: 1

CLAIMS PAYMENT SUMMARY

	CLAIMS PAID/DENIED	CLAIMS PO AMT.	WITHHELD AMOUNT	NET PAY AMOUNT	CREDIT AMOUNT	NET 1099 AMOUNT
CURRENT PROCESSED	2	575.00	0.00	575.00	0.00	575.00
YEAR-TO-CIATE TOTAL	630	11480.00	50.00	1143.00	0.00	1143.00

REMITTANCE 'STATEMENT

Page 5

AS OF 01/06/84 KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

RA NUMBER PROVIDER NAME
RS SEQ NUMBER 2 PROVIDER NUMBER

CLAIM TYPE: MENTAL HOSPITAL

DESCRIPTION OF EXPLANATION CODES LISTED ABOVE

061 PAID IN FULL BY MEDICAID
254 THE RECIPIENT IS NOT ELIGIBLE ON DATES OF SERVICE
260 ELIGIBILITY DETERMINATION IS BENG MADE
365 FEE ADJUSTED TO MAXIMUM ALLOWABLE
999 REQUIRED INFORMATION NOT PRESENT

AS OF 07/08/87 KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMFNT Page 6

RA NUMBER
RA SEQ NUMBER 41

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: INPATIENT SERVICES

• MASS ADJUSTMENTS*

INVOICE NUMBER	-RECIPIENT NAME	IDENTIFICATION- NUMBER	INTERNAL CONTROL NO.	DATES Of SERVICE	TOTAL CHARGES	PROF COMP	AMT. FROM OTHER SOURCES	CLAIM PHT AMOUNT	EOB
**ADJUSTMENT TO CLAIM 9887009452010. ORIGINALLY PAID ON 011387									
FOR RECIPIENT BERRY'		A RECIP# 123456789							
PROVIDED 031286-033186		BILLED 2100.00	PAID 3717.80						
** NEW CLAIM 87188-300-001									
	BERRY	173456789	6087188-300-001	031786-033186	2100.00	0.00	0.00	3787.10	343
1	ACCOM/ANCIL B	MOD	QTY 20	031286-033186	2000.00	0.00		0.00	343
2	ACCOM/ANCIL X	HOD	QTY 5	031286-033186	100.00	0.00		0.00	343
**ADJUSTMENT TO CLAIM 9887009452000. ORIGINALLY PAID ON 011387									
FOR RECIPIENT RJDWELL		OP RECJP # 654321234							
PROVIDED 030186-033186		BILLED 3150.00 PAID	5767.59						
• *NEW CLAIM 87188-300-000									
	BIDWELL 0	654371234	6087188-300-000	030186-033186	3150.00	0.00	0.00	5820.00	343
1	ACCOM/ANCIL B	NOD	QTY 31	030186-033186	3100.00	0.00		0.00	343
2	ACCOM/ANCIL X	MOD	QTY 1	030186-033186	50.00	0.00		0.00	343

CLAIMS MASS AOJ IN THIS CATEGORY: 2 TOTAL BILLED: 5,250.00 TOTAL PAID: 9.607.10
MASS ADJUSTED AMOUNT: 126.71-

PROVIDER INQUIRY FORM

PROVIDER INQUIRY FORM

EDS
P.O. Box 2009
Frankfort, Ky. 40602

Please remit both copies of the Inquiry Form to EDS.

1 Provider Number | 3 Recipient Name (first, last)

2 Provider Name and Address | 4 Medical Assistance Number

5. Billed Amount | 6. Claim Service Date

7 RA Date | 8. Internal Control Number

9 Provider's Message

10. _____
Signature Date

Dear Provider:

_____ This claim has been resubmitted for possible payment.

_____ EDS can find no record of receipt of this claim. Please resubmit.

_____ This claim paid on _____ in the amount of _____

_____ We do not understand the nature of your inquiry. Please clarify.

_____ EOS can find no record of receipt of this claim in the last 12 months.

_____ This claim was paid according to Medicaid guidelines.

_____ This claim was denied on _____ for EOB code _____

_____

_____ Aged claim. Payment may not be made for services over 12 months old without proof that the claim was received by EDS within one year of the date of service; and if the claim rejects, you must show timely receipt by EDS within 12 months of that rejection date. Claims must be received by EDS every 12 months to be considered for payment.

Other _____

_____

_____

_____

_____

_____
EDS Date

ADJUSTMENT REQUEST FORM

MAIL TO: EDS FEDERAL CORPORATION
P.O. BOX 2009
FRANKFORT, KY 40602

ADJUSTMENT REQUEST FORM

1. Original Internal Control Number (I.C.N.)	EDS FEDERAL USE ONLY	
2. Recipient Name	3. Recipient Medicaid Number	
4. Provider Name/Number/Address	5. From Date Service	6. To Date Service
	7. Billed Amt.	8. Paid Amt. / 9. R.A. Date

10. Please specify WHAT is to be adjusted on the claim.

11. Please specify REASON for the adjustment request or incorrect original claim payment.

IMPORTANT: THIS FORM WILL BE RETURNED TO YOU IF THE REQUIRED INFORMATION AND DOCUMENTATION FOR PROCESSING ARE NOT PRESENT. PLEASE ATTACH A COPY OF THE CLAIM AND REMITTANCE ADVICE TO BE ADJUSTED.

12. Signature 13. Date

EDSF USE ONLY----DO NOT WRITE BELOW THIS LINE

Field/Line:
New Data:
Previous Data:

Field/Line:
New Data:
Previous Data:

Other Actions/Remarks:

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

CODING ADDENDUM

Following is a list of revenue codes accepted by KMAP on the UB-82 billing statement in form locator 51:

REVENUE CODE	DESCRIPTION	STANDARD ABBREVIATION
114	PRIVATE BED PSYCHIATRIC	PSTAY/PVT
124	TWO BED PSYCHIATRIC	PSTAY/2BED
134	THREE BED PSYCHIATRIC	PSTAY/3BED
154	WARD PSYCHIATRIC	PSTAY/WARD
250	PHARMACY	PHARMACY
270	MEDICAL/SURGICAL SUPPLIES	MED-SUR SUPPLIES
300	LABORATORY	LAB
320	RADIOLOGY (DIAGNOSTIC)	DX X-RAY
330	RADIOLOGY (THERAPEUTIC)	RX X-RAY
350	CT SCAN	CT SCAN
351	CT HEAD SCAN	CT SCAN/HEAD
352	CT BODY SCAN	CT SCAN/BODY
610	MRI	MRI
611	MRI BRAIN	MRI-BRAIN
612	MRI SPINAL CORD	MRI-SPINE
730	EKG/ECG	EKG/ECG
740	EEG	EEG
901[1]	[1]ELECTRO SHOCK TREATMENT	ELECTRO SHOCK
960	PRO FEE (To Be Used Only for Hospital-Based Physicians Other Than Psychiatrists)	PRO FEE
961	PSYCHIATRIC PRO FEE	PRO FEE/PSTAY
971	LAB PRO FEE	PRO FEE/LAB
972	RADIOLOGY (DIAG) PRO FEE	PRO FEE/RAD/DX
973	RADIOLOGY (THER) PRO FEE	PRO FEE/RAD/RX
974	RADIOLOGY NUCLEAR MEDICINE	PRO FEE/NUC MED
985	EKG/ECG PRO FEE	PRO FEE/EKG
986	EEG PRO FEE	PRO FEE/EEG
001	TOTAL CHARGES	

[1] NOTE - When billing professional component services for electro shock treatment, use Revenue Code 960.

CODING ADDENDUM

The following revenue codes (column A) are professional component revenue codes and cannot be billed unless they are billed in conjunction with the revenue codes in column B.

A	B
971 MUST BE IN CONJUNCTION WITH	300
972 MUST BE IN CONJUNCTION WITH EITHER	320, 350, 351, 352, 610, 611, or 612
973 MUST BE IN CONJUNCTION WITH	330
974 MUST BE IN CONJUNCTION WITH EITHER	350, 351, or 352
985 MUST BE IN CONJUNCTION WITH	730
986 MUST BE IN CONJUNCTION WITH	740

CODING ADDENDUM - ALL INCLUSIVE ANCILLARY REVENUE CODE

Following is a list of revenue codes accepted by KMAP on the UB-82 billing statement in form locator 51 when revenue code 240, All Inclusive Ancillary is used:

REVENUE CODE	DESCRIPTION	STANDARD ABBREVIATION
114	PRIVATE BED PSYCHIATRIC	PSTAY/PVT
124	TWO BED PSYCHIATRIC	PSTAY/2BED
134	THREE BED PSYCHIATRIC	PSTAY/3BED
154	WARD PSYCHIATRIC	PSTAY/WARD
240	ALL INCLUSIVE ANCILLARY	ALL INCL ANCIL
960	PRO FEE (To Be Used Only for Hospital-Based Physicians Other Than Psychiatrists)	PRO FEE
961	PSYCHIATRIC PRO FEE	PRO FEE/PSTAY
001	TOTAL CHARGES	